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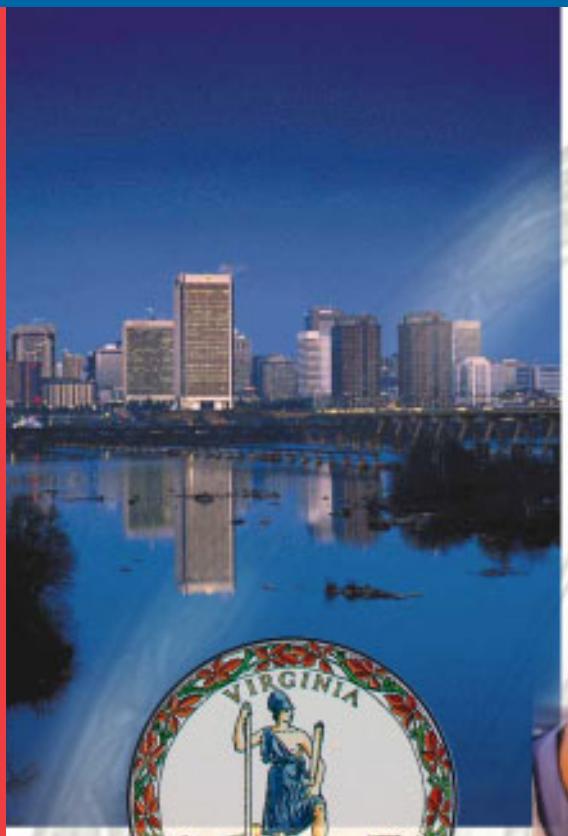

Commonwealth of Virginia

Virginia Department of Medical Assistance Services

External Quality Review

Annual Report

SFY 2002

We Don't Provide Healthcare...We Make It Better

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Section I

Executive Summary

Introduction

The Virginia Department of Medical Assistance Services (DMAS) currently administers three Medicaid programs that serve residents throughout the Commonwealth: a traditional Fee-For-Service and two managed care programs. The first of these two managed care initiatives, MEDALLION, is modeled on a primary care case management (PCCM) system of care where enrollees are assigned a primary care provider (PCP) who provides a medical home and serves as a gatekeeper to specialty services. As of November 2003, more than 1,700 PCPs participated in the MEDALLION program. Another Medicaid Managed Care program is Medallion II that contracts with managed care organizations (MCOs) to deliver comprehensive health care and services to eligible enrollees under a capitated arrangement. Similar to the MEDALLION program, Medallion II enrollees select or are assigned a PCP. Five MCOs currently participate in the Medallion II program.

DMAS is additionally responsible for the Family Access to Medical Insurance Security (FAMIS) Program. FAMIS is Virginia's State Children's Health Insurance Program (SCHIP) and was created as a part of the Balanced Budget Act of 1997. FAMIS provides coverage for uninsured children who are low income, but not eligible for Medicaid. DMAS contracts with the same MCOs for both the Medallion II and FAMIS programs. In addition, the networks of PCPs, specialists, and hospitals are the same in both Medallion II and FAMIS. FAMIS children living in the Central, Northern, West, Southwest, and Tidewater areas of Virginia access FAMIS health care services through a contracted MCO operating in their area. In a few areas where MCOs are not yet available, FAMIS children receive benefits through the FAMIS PCCM or Fee-For-Service (FFS) programs.

To fulfill federal requirements for the Medicaid managed care programs, DMAS contracts with Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO). In this capacity Delmarva completed a number of reviews and studies to assess the quality, access, and timeliness of medical care and services delivered to Medicaid and FAMIS enrollees. These initiatives focused primarily on the state fiscal year (SFY) 2002 that began on July 1, 2001, and ended June 30, 2002. However, additional activity occurred in SFY 2003 to assess progress made since the initial findings were

reported. Before discussing these results, a brief history of the Medicaid managed care programs and changes that occurred during this review period is provided.

History

In December 1991, the Centers for Medicare & Medicaid Services (CMS) granted approval of Virginia's application for a 1915(b) waiver to implement its first managed care program, MEDALLION PCCM. This program started in four pilot cities and counties in January 1992. Statewide expansion was completed in 1995, making Virginia one of the first states to expand program eligibility beyond eligible enrollees under the Temporary Assistance for Needy Families (TANF) to also cover aged, blind, and disabled beneficiaries. With the approval of the 2002 waiver renewal, DMAS began implementing several program enhancements, including new materials for enrollees and providers, revised PCP agreements, and a renewed focus on improving health outcomes.

In January 1996, DMAS introduced Medallion II, a mandatory managed care program delivered through contracted MCOs. The service area was initially limited to seven Tidewater localities but was expanded in November 1997 to an additional six cities and counties adjacent to Tidewater. Continued expansion occurred throughout Virginia. After the December 2001 expansion, the Medallion II program was available in 103 localities with a membership of approximately 243,000 Medicaid enrollees. The Medallion II program was modified for this expansion to allow both MEDALLION and Medallion II to operate concurrently in 33 areas. There are currently five contracted MCOs in the Medallion II program: Anthem HealthKeepers, CareNet/Southern Health, Sentara Family Care, UNICARE HealthPlan of Virginia by WellPoint, and Virginia Premier MCO. UNICARE is the newest of these contracted MCOs, commencing operations in 2001.

Family Access to Medical Insurance Security (FAMIS) is Virginia's State Children's Health Insurance Program (SCHIP) and complies with federal regulations in the 1997 Balanced Budget Act. Children with incomes less than or equal to 200% federal poverty levels and who are ineligible for private health insurance and Medicaid are eligible for FAMIS. DMAS contracts with the same seven managed care organizations that provide Medallion II services to Medicaid recipients, and these organizations provide preventative health care services and well childcare to FAMIS recipients. Differences between the two managed care program lie within application and eligibility determinations, delivery systems, benefits and cost sharing. FAMIS is designed to resemble health insurance programs offered by private employers. As of July 1, 2003, enrollment in the various programs administered by DMAS is as follows:

- Fee-For-Service—240,242 enrollees;
- MEDALLION—80,796 enrollees;

- Medallion II—262,961 enrollees; and
- FAMIS—52,327 enrollees.

External Quality Review - Activities

As Virginia's contracted EQRO, Delmarva performed several activities that are discussed in this report, including:

- A comprehensive desktop review of UNICARE in the areas of quality improvement, utilization management, and grievances and appeals. The review was more in-depth, as UNICARE began operations in December 2001 and was not included in the onsite MCO review conducted in 2002.
- Desktop reviews of four remaining MCOs to evaluate progress made to address 2001 deficiencies identified in quality improvement, utilization management, and grievances and appeals.
- Desktop reviews of two MCO quality improvement studies to evaluate outcomes from project modifications initiated in 2001.
- Assessment of the pharmacy management practices of all contracted MCOs through review and analysis of each MCO's responses to a pharmacy survey.
- Two CAHPS® 2003 surveys of MEDALLION, Medallion II, and FAMIS enrollees.
- A survey to assess enrollee access to their PCP outside of normal office hours.
- Two clinical focused studies to retrospectively evaluate quality of care based upon review of medical records and administrative data from SFY 2002 (July 1, 2001-June 30, 2002). Studies were performed in the following clinical domains:
  - Immunization compliance rates at 24 months
  - Adequacy of prenatal care

The two areas of focused clinical review were selected because they 1) address conditions that affect a high proportion of Medicaid enrollees in the managed care programs, 2) have the potential to positively impact medical resource utilization, 3) are important in ensuring the quality of care, and 4) may be compared with baseline results from previous studies to assess improvements.

This annual report provides a review of recent studies conducted by Delmarva as the EQRO to assess the progress that Medicaid managed care systems have made in fulfilling the goals of DMAS. Strengths and weaknesses were derived from an in-depth review of each study with comparisons against contractual requirements to focus on the provision of quality care and the timeliness of, and access to needed services.

External Quality Review - Findings

Quality Review

As a follow-up to the 2002 comprehensive onsite review of four of the MCOs operating in 2001, Delmarva conducted a desktop review in 2003 to assess the MCOs' level of compliance with Medallion II contractual requirements and standards of practice in three categories: quality improvement, utilization management, and grievances and appeals. Additionally, a comprehensive desktop review was conducted of UNICARE in all three categories since, as a newly contracted MCO, it was not assessed in 2002. The UNICARE review consisted of multiple sections deemed "not applicable" because their data and enrollment periods necessary to conduct the care and services had not been in place long enough to be representative of operational performance in 2002. A pharmacy management review was also included in the assessment of systems performance for each MCO.

Overall, the strong performance of the MCOs noted in the 2002 findings was found to be even more robust as opportunities for improvement were realized in the system responses to identified deficiencies. In general, the MCOs performed well on components of the review related to quality management, with comprehensive, well-defined quality improvement programs, supporting policies and procedures, quality improvement studies, and effective integration of quality improvement activities with other management activities. Similarly, the Medicaid MCOs have established utilization management programs that facilitate enrollee access to medically necessary, appropriate care with policies and procedures that outline time frames for decision-making and notification requirements. Mechanisms are in place to detect over- and underutilization and implement corrective action in response to any identified trends or quality of care concerns. All MCOs have grievance systems that support members' rights to file a grievance or appeal; provide for timely resolution and communication of the outcome; and track and trend data to identify opportunities for improvement. Assessment of pharmacy management components demonstrated that each of the MCOs have established appropriate processes and procedures supporting formulary management, Pharmacy and Therapeutics Committee functions, and clinical programs based on quality-focused industry standards.

The CAHPS® 2003 Survey

CAHPS® is a standardized survey used industry- wide in both the Commercial, Medicare, and Medicaid sectors to solicit enrollees' feedback on their level of satisfaction with the delivery of health care and related services. As in past surveys, Delmarva contracted with WB&A Market Research, a marketing company and licensed CAHPS® vendor, to conduct a telephonic survey of MEDALLION, Medallion II, and FAMIS enrollees between June and July of 2003. Child surveys were implemented for all groups; however, the adult survey conducted by WB&A was limited to MEDALLION Medicaid enrollees since the MCOs assumed responsibility for surveying their adult Medallion II enrollees. The Medallion II Adult Survey was conducted by another firm, Westat and Schaller Consulting, and was case mixed adjusted. Survey results for all groups, including Medallion II adults, were generally comparable to or exceeded national Medicaid and commercial

benchmarks as reported by the National CAHPS® Benchmarking Database. Particularly noteworthy are the high scores of enrollees' overall satisfaction with their MEDALLION or Medallion II MCO. These scores often exceeded national benchmarks by a wide margin. For example, for the MEDALLION adult respondents, 60% rated their satisfaction at the highest level of 9 or 10, whereas the national adult Medicaid benchmark stood at 50% and the adult commercial benchmark at only 41%.

Access to Care Study

Physicians participating in the MEDALLION program as well as all MCOs providing care to enrollees of Medallion II plans are contractually required to provide access to medical service information 24 hours per day, 7 days per week. Although direct contact with medical personnel is not required, electronic answering systems must provide emergency contact information. Results of a second telephonic survey of 24-hour/7-day phone access to physicians revealed substantial improvement in rates of reaching valid provider phone numbers with emergency contact information. Ninety percent (90%) of providers participating in the MEDALLION and Medallion II programs had valid phone numbers and answered within six rings, as compared with 70% using the same review criteria in 2002. Additionally, the percentage of answering machines providing emergency contact information increased for both programs.

Clinical Focus Studies – Prenatal and Childhood Immunizations at 24 months

Clinical focus studies provide an opportunity to increase understanding in relation to utilization of high-volume, high-risk, high-cost, and problem-prone aspects of health care services. For this most recent review period, topics for study included childhood immunizations and prenatal care. Both of these services affect a large percentage of the Medicaid population. Additionally, appropriate provision of primary care has been demonstrated to reduce future adverse health conditions and decrease costs associated with more intensive treatment or ongoing care. In each of these areas, results for Virginia's Medicaid programs were significantly above national Medicaid benchmarks and, in some cases, immunization rates exceeded overall Virginia and U.S. general population benchmarks. Specific details of results from each of these studies are presented in the next section; highlights are outlined below.

- Approximately 77% of pregnant women in Medicaid during SFY 2002 had adequate prenatal care. The rates of low and very low birth weight babies born to women in Medicaid during this period were 7.4% and 1.8%, respectively.
- In SFY 2002 compliance rates for up-to-date immunizations for children at 24 months of age exceeded the DMAS target of 85% for all of the single customary immunizations, with the 4:3:1 series (4 DTP/3 polio/1 MMR) only slightly below at 84%.

Conclusions

This annual review of the contracted Medicaid MCO's structures, processes, and outcomes that support Virginia's two managed care delivery systems show continued progress in meeting the goals established by DMAS. Key performance areas assessed include the quality, access, and timeliness to care and services provided to the enrollees by each MCO. While the additional goal of reducing unnecessary and costly health expenditures for the Medicaid population was beyond the scope of this analysis, findings suggest that the quality-driven systems of care developed by DMAS are achieving program goals as well.

The results of several studies and reviews completed by Delmarva during SFY 2002 confirm that DMAS and its partners have continued to demonstrate progress in enhancing access to routine and urgent primary care, improving patient and provider compliance with established standards of care. The analysis also revealed that the Medicaid MCOs had effective structures and processes in place to promote quality care, which demonstrated a clear framework for addressing concerns and for supporting new opportunities for improvement. The results from specific clinical focus studies support the positive impact that managed care has had on continued improvement in prenatal care and compliance with required immunizations for children at age 2. Both MEDALLION and Medallion II enrollees have indicated high levels of satisfaction with their MCO and the delivery of health care services, as evidenced by their responses on the recent CAHPS® surveys. As in the past, Virginia continues to meet or exceed national benchmarks in most areas.

Unlike many states that have experienced difficulty in maintaining stable Medicaid managed care participation, Virginia has created effective, stable partnerships with its MCOs. In fact, one additional MCO began operations during 2001. Review of MCO systems for quality, utilization, and grievances substantiates strong performance in relation to these standards. In the aggregate nearly all components were met or at least partially met during the current desktop review, with the exception of one MCO.

During SFY 2002, DMAS continued its expansion of the Medallion II program throughout Virginia. Modification of the CMS 1915(b) waiver allowed DMAS to concurrently operate both managed care delivery systems, Medallion II and MEDALLION, in these new localities. Looking ahead, it will be important to conduct comparative studies to determine any differences in population, utilization, and clinical and service outcomes between these two systems of care in continuing to shape effective and responsive delivery of high-quality health care services to Medicaid enrollees. This may also present additional opportunities to identify best practices.

A review of the studies shows an expected increase in minority groups enrolled in the Medallion II and FAMIS programs. This increase has major implications for the development of effective and culturally appropriate interventions directed at increasing access to these groups. Health care studies have shown that health status among minority racial/ethnic groups in United States lag behind that of the white population;

and that access of minorities to medical care is compromised (Pediatrics, 2000). The Medallion II contract requires Medallion II MCOs to provide enrollee materials in second language if that language is above 5% of the total enrollment, however, those minority racial/ethnic groups under 4.99% might require a closer review to see if their care and services are delivered in a culturally appropriate manner.

The following "AT A GLANCE" sections provide a snapshot of the 2002 Virginia Medicaid Managed Care program's strengths and opportunities for improvement. Results are compared to findings from each of the studies referenced above as they relate to three key areas of performance: quality of, access to and timeliness of care and services delivered to the Medicaid Managed Care enrollees. To assist in building on the strengths of the programs reviewed in 2002, Delmarva has submitted recommendations for consideration in Section V. These recommendations are independent of those included in each of the Delmarva studies but draw from the findings of those studies individually and in the aggregate.

Section II – Access AT A GLANCE

Access to necessary care and services has historically been a challenge for Medicaid recipients enrolled in fee-for-service programs. One of DMAS' major goals in securing approval of the 1915(b) Medicaid waiver application was to develop managed care delivery systems that would remove existing barriers for Medicaid enrollees, thereby improving their overall health status, increasing their quality of life, and reducing costly health expenditures related to a fragmented system of care. The following sections provide information from outcomes of several studies conducted during SFY 2002, and can serve as a barometer of Virginia's progress in meeting the above goals for the Medicaid Managed Care Program. Both strengths and opportunities for improvement are identified.

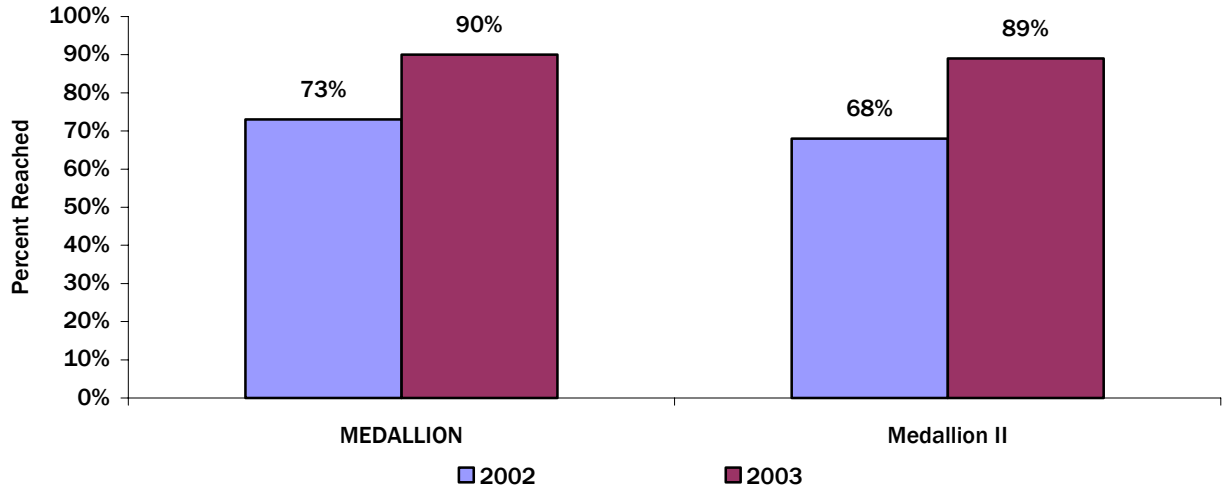
Strengths

24-Hour/7-Day Access to Care

The ability to reach one's provider telephonically as needed is an extremely important measure of access to care and services. Twenty-four/seven (24/7) day phone access can provide patients with critical and timely information to help them their manage their care more effectively, and to reduce associated medical costs related to emergency room utilization or potential exacerbation of illnesses or medical conditions requiring readmission to acute care facilities. In recognition of the significance of 24/7 phone access to care for enrollees in the MEDALLION and Medallion II programs, a telephonic survey was conducted in 2003 to evaluate access to care. Unlike a similar survey conducted in 2002, the 2003 survey focused exclusively on access outside of normal office hours. Figure 1 compares the initial disposition of calls made during the 2002 and 2003 surveys. Results reveal that 90% of providers in the MEDALLION sample and 89% in the Medallion II sample had valid phone numbers that were answered within six rings. This reflects considerable improvement over 2002 when only 73% of calls reached the desired MEDALLION provider and 68% of calls to a Medallion II provider were successful. Results were consistent across periods as well as Medallion II MCOs and the three largest specialty groups: pediatrician (94%), family practice (89%), and internal medicine (86%). There was not enough evidence to conclude that there were issues with access to care among the groups evaluated.

Figure 1. Providers with Valid, Answered Phone Numbers

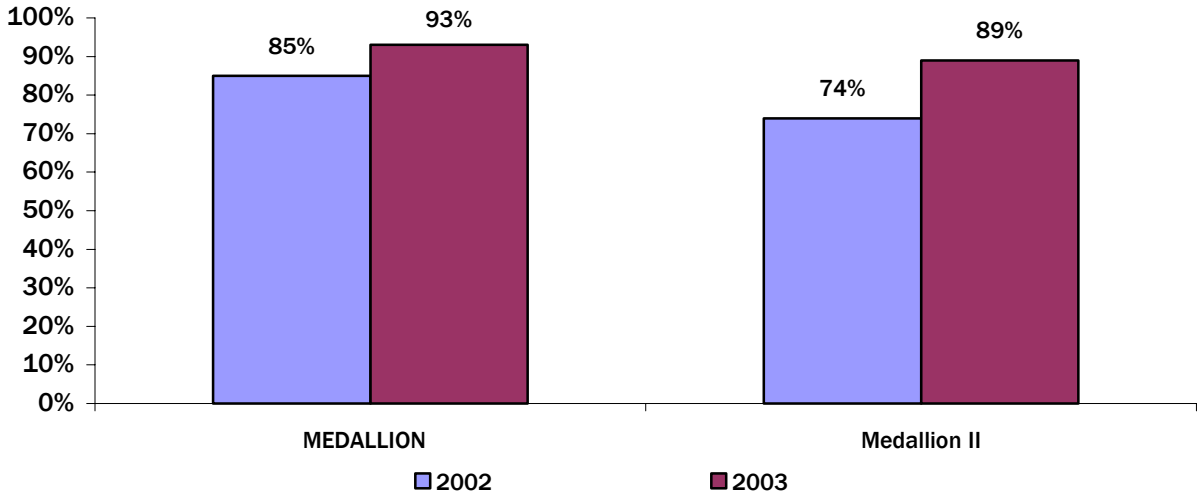
Source: 24-7 Access Study 2003



Of the valid phone responses, a person answered one-third of the times called, while electronic answering devices answered the remaining two-thirds. Upon examination it was determined that 90% of all answering machines provided needed information regarding who to call or how to access services in an emergency. Although there were slight differences between MEDALLION and Medallion II providers at 93% and 89%, respectively, they were not statistically significant. As shown in Figure 2, the percentage of answering machines with emergency contact information increased by 8% for MEDALLION providers and 15% for Medallion II providers as compared with the 2002 survey results.

Figure 2. Percentage of Answering Machines with Emergency Contact Information

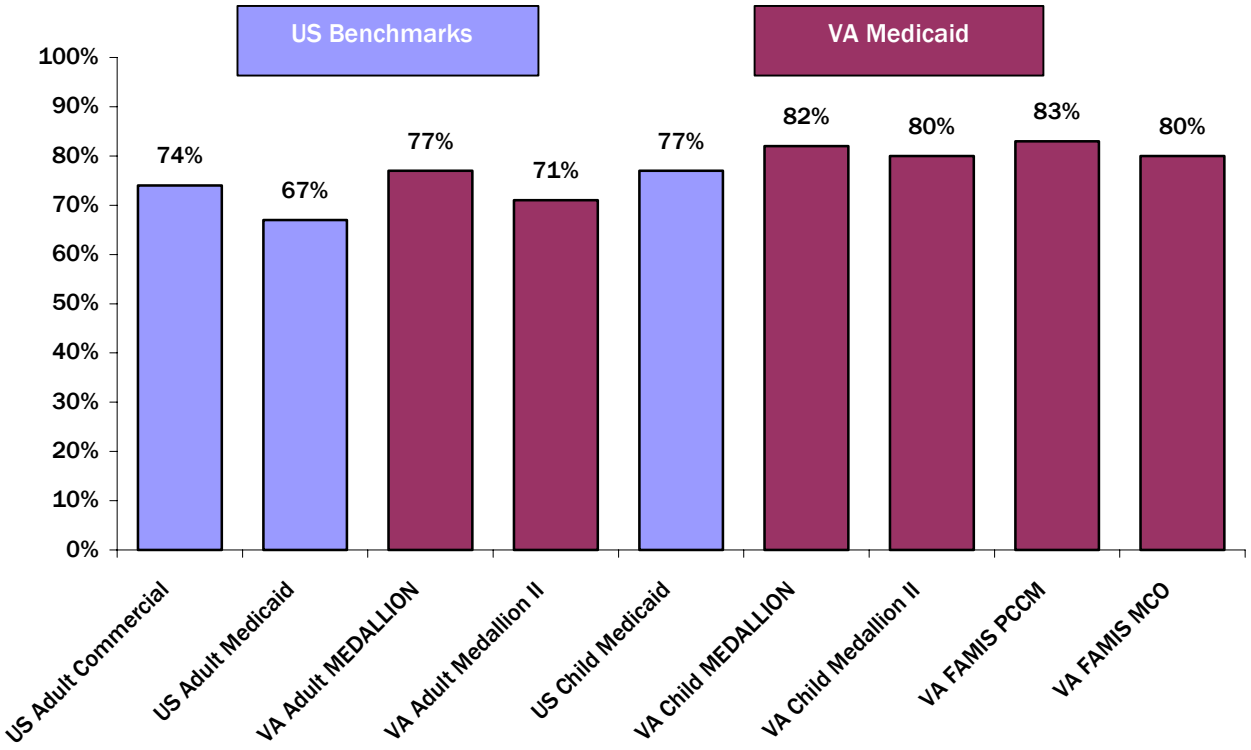
Source: 24-7 Access Study 2003



Getting Needed Care

The composite scores from the 2003 CAHPS® surveys indicate that enrollees have had no problems with most issues related to getting needed care as represented by a satisfaction score of "9" or "10." Only 10% or 5 survey groups (MEDALLION Adult, MEDALLION Child, FAMIS PCCM, Medallion II Child, FAMIS MCO) responded that getting needed care was a major problem. This compares favorably with CAHPS® national Medicaid and commercial benchmarks as illustrated in Figure 3. Specifically, within this domain over 80% of all but two categories of respondents indicated that they had no problems getting necessary care, tests, or treatment and, with the exception of Medallion II adults, 90% or more reported no problems with delays in health care while awaiting approval from their MCO. Aggregate results for Medallion II adult respondents were considerably lower at 64% and present an opportunity for improvement.

Figure 3. Getting Needed Care Composite Scores
Sources: VA CAHPS Survey and National CAHPS Benchmarking Database, 2003



Access to Prenatal Care

Access to prenatal care was found to be good in the SFY 2002 Prenatal Care Clinical Study conducted by Delmarva. Ninety-six percent (96%) of all pregnant women received care within four weeks of enrollment in a Medicaid program. While this is a slight decrease from 98% in SFY 2000, it nevertheless demonstrates effective outreach and lack of barriers to receiving necessary care. Although the survey numbers are small, 100% of CAHPS® survey respondents who were currently pregnant or gave birth in the last six months reported they had seen a doctor for prenatal care. Table 1 provides a breakdown by program type of the findings from the Prenatal Care Clinical Study. There is little difference in rates between Fee-For-Service, MEDALLION, and Medallion II programs.

Table 1. Initiation of Prenatal Care by Program Type for Newly Eligible Pregnant Women that Gave Birth During SFY 2002 (Source: Prenatal Care Clinical Study SFY 2002)

	Fee-For-Service % (N)	MEDALLION % (N)	Medallion II % (N)	Medicaid All Program Aggregate % (N)
Newly Medicaid Eligible	96% (2,646)	97% (3,224)	95% (8,053)	96% (13,923)

MCO Access to Prescription Medicine

Assessment of each MCO's pharmacy management program confirmed that policies and procedures were in place to ensure that enrollees' access to necessary pharmacy services is not inappropriately restricted. For example, in a closed formulary environment, it is critical that processes are in place to ensure that a beneficiary does not leave the pharmacy without the prescribed medication or a clear understanding of the process that must be completed prior to receipt of a medication. Each MCO demonstrated adequate messaging to the dispensing pharmacist at the point of sale and generally allowed for a bridge supply of medication if clinically appropriate. Additionally, access to a member services call center is available in order to assist the enrollee, provider, or pharmacist with any questions or concerns related to non-formulary medications. All MCOs have an adequate communication or grandfathering strategy for medications that are moved from a closed to a non-formulary status.

Further evidence supporting access to prescription medicine is provided by CAHPS® survey respondents. Eighty-two percent (82%) to 94% of survey respondents from MEDALLION, FAMIS PCCM, Medallion II, and FAMIS MCO reported no problems in obtaining a new or refilled prescription for their child. Of those members who experienced a problem, over one-half reported receiving assistance. It is interesting to note that MEDALLION enrollees, including FAMIS PCCM, are slightly more likely to have received a new or refilled prescription—a statistically significant increase over 2001 levels—and indicate fewer problems in having the prescription filled. Interesting to note that at the time of this study, DMAS had no formulary, thus new process initiated later to manage costs might show changes in future survey responses. Table 2 illustrates these comparisons for CAHPS® survey respondents.

Table 2. Access to Prescription Medicine (Source: CAHPS® Survey 2003)

	MEDALLION Child	FAMIS PCCM	Medallion II Child	FAMIS MCO
Received a new or refilled prescription	74%	75%	64%	63%
Experienced no problem in getting prescription filled	94%	94%	82%	84%
Received help if there was a problem	57%	57%	56%	67%

Transportation

Transportation often presents access barriers to enrollees seeking medical care from a physician or health care provider. It is therefore important that managed care delivery systems have effective processes in place to identify and meet enrollees' transportation needs. According to CAHPS® survey data, MEDALLION adult enrollees requested assistance with transportation significantly less often in 2003 compared with 2001, whereas requests for MEDALLION and Medallion II child enrollees remained fairly constant. There was a decrease in Medallion II children receiving transportation assistance in 2003; however, this group continued to demonstrate the highest scores for transportation needs being met. The CAHPS® survey results displayed in Table 3 indicate that the managed care delivery systems are generally meeting the transportation needs of enrollees and facilitating access to necessary care and services.

Table 3. Transportation Needs (Source: CAHPS® Survey 2003)

Survey Subpopulation	Called to Receive Help		Received Help		Transportation Needs Met Always or Usually	
	2001	2003	2001	2003	2001	2003
MEDALLION Adult	21%	12%	63%	65%	66%	68%
MEDALLION Child	5%	4%	60%	67%	61%	60%
Medallion II Child	10%	9%	83%	70%	77%	79%

Interpreter Services

The number of MEDALLION Adults, MEDALLION Children, and Medallion II children needing interpreter services is extremely low at 2% based on CAHPS® survey findings from 2003. MEDALLION children needing an interpreter were reported at only 1%. These numbers are consistent with results from the 2001 survey. Access to an interpreter when needed had a wide range of scores for each year reviewed, as well as an exceptionally small sample size, thus preventing any year-to-year or delivery system comparisons. In the absence of this, one can look at data as an indirect measure of enrollee satisfaction with interpreter services.

Only 4% to 7% of enrollees who responded to the CAHPS® survey reported calling in or writing the MCO with a problem or grievance. Satisfaction with the resolution was generally quite high as displayed in Table 4.

Table 4. Enrollees with Problems or Grievances (Source: CAHPS® Survey, 2003)

Survey Subpopulation	Problem or Complaint	Satisfaction with Resolution
MEDALLION Adult	7%	67%
MEDALLION Child	4%	100%
FAMIS PCCM	6%	79%
Medallion II Child	6%	89%
FAMIS MCO	7%	92%

A review of a separate report containing Medallion II Adult CAHPS® survey results show that of those Medallion II Adult respondents who called or wrote their MCO with a problem or grievance, 34% reported that their MCO responded the same day, 36% reported they received a response within two to twenty-one days, and 30% responded that they did not receive a response. In the same survey, it is interesting to note the 80% of the respondents reported their MCO settled the grievance to their satisfaction. One could stipulate that most of the Virginia Medicaid MCOs have effective systems in place to facilitate or to address enrollee concerns with access to care and services. The CAHPS® survey is conducted every two years by DMAS.

Opportunities for Improvements

Prenatal Care for Fee-For-Service

Fewer women in the Fee-For-Service (FFS) program began prenatal care in the first trimester and received the expected number of visits compared with women in the managed care programs. This low number may be explained by late enrollment into the Medicaid program. Under DMAS policy, when a woman applies for Medicaid and is eligible due to pregnancy, she is placed into FFS by default. Later, the woman is transferred into the MEDALLION or Medallion II program. Women who apply for Medicaid late in their pregnancy are unlikely to have time to be moved into another program before giving birth, thus they would receive care under the FFS program. As a result, these women in the FFS program may not have one "gatekeeper" who ensures continuity of care and services specific to their needs. Table 5 displays the composite scores of women by program type who received adequate prenatal care based upon initiation of care within four months of conception and receipt of the expected number of visits.

Table 5. Percentage of Mothers Receiving Adequate Prenatal Care by Program Type that Gave Birth During SFY 2002 (Source: Prenatal Care Clinical Study, SFY 2002)

Percentage of Mothers Receiving Adequate Prenatal Care	
Fee-For-Service	68%
MEDALLION	82%
Medallion II	76%

The minority distribution of births in the FFS program has shifted dramatically from SFY 2000 when only 9% of births represented minorities, exclusive of African Americans. In SFY 2002, Hispanic women alone accounted for 30% of all FFS births. This finding could present a clear opportunity to develop effective strategies to increase earlier enrollment in Medicaid for this population because the data shows that women who are enrolled in MEDALLION and Medallion II programs receive prenatal care within four weeks of enrollment. In addition, this increase might assist Virginia to focus on the development of culturally appropriate outreach strategies that increase access to prenatal care for Hispanic women enrolled in the Medallion II and MEDALLION programs. Table 6 illustrates the racial/ethnic distribution by program.

Table 6. Racial Distribution by Program for Virginia Medicaid Enrollees that Gave Birth During SFY 2002 (Source: Prenatal Care Clinical Study, SFY 2002)

Delivery System	White	African American	Asian	Hispanic	Other
All Medicaid	51%	38%	3%	8%	0%
Fee-For-Service	38%	24%	7%	30%	1%
MEDALLION	78%	18%	2%	2%	0%
Medallion II Child	45%	51%	2%	2%	0%
Medallion II Adult	35%	51%	6%	Not identified	5%

The racial distribution above also suggests that Virginia might consider a review of whether MCOs are effectively assessing and addressing the language and cultural needs of their Asian and Hispanic enrollees. The Commonwealth Funds 2001 Survey found that minority populations are more apt to have difficulties communicating with their primary care providers than whites.

Section III – Timeliness AT A GLANCE

Access to necessary health care and related services alone is insufficient in advancing the health status of Medicaid enrollees. Equally important is the timely delivery of those services, which is an additional goal established by DMAS for the systems of care developed to serve Medicaid enrollees. The following sections examine several measures that address the success of these systems in promoting timely receipt of services and provide comparisons to established benchmarks. Program strengths as well as opportunities for improvement are identified.

Strengths

Timely Initiation of Prenatal Care

Initiation of prenatal care during the first trimester of pregnancy has been linked to reductions in the likelihood of complications and premature delivery. Complications and premature births can result in long-term health problems for the child as well as extremely large expenditures for the health care system. In conducting its second study of prenatal care for participants in the MEDALLION and Medallion II programs, Delmarva found that the majority of women (77%) in Medicaid who gave birth in SFY 2002 began prenatal care in the first trimester of pregnancy. Figure 4 displays the trend analysis of initiation of prenatal care within the first trimester of pregnancy (SFY 1998–2002). Gains made in SFY 2000 have been sustained in SFY 2002.

Figure 4. Trends in Timely Initiation of Prenatal Care Within First Trimester for All Medicaid
Source: Prenatal Care Clinical Study, 2003

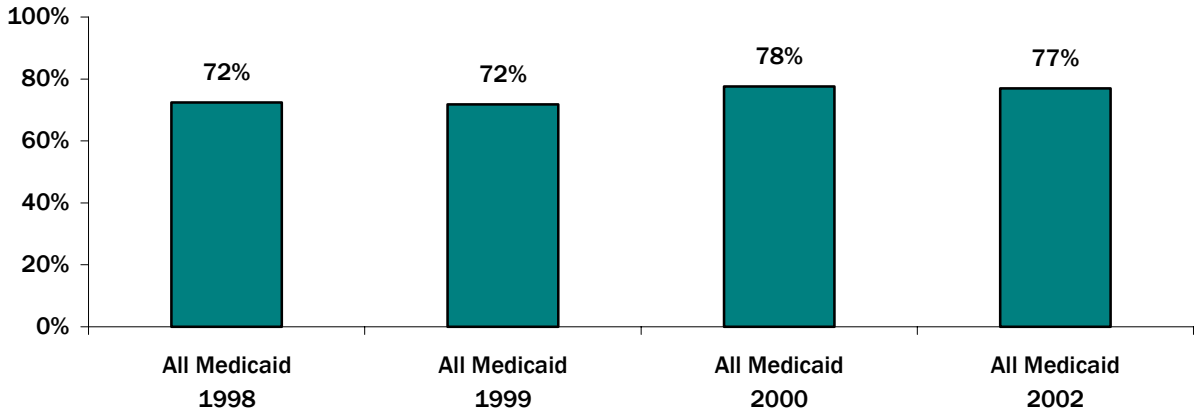
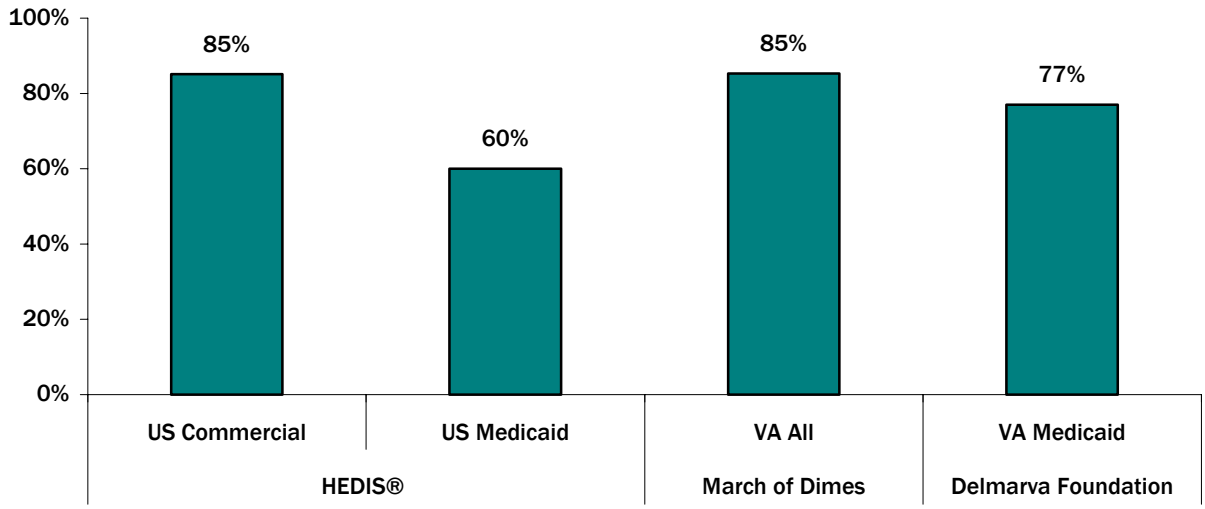


Figure 5 displays the national HEDIS® results for commercial and Medicaid populations and Virginia statewide results (from March of Dimes and Virginia Medicaid based on most current data available).

Although somewhat below the overall rates in Virginia and the United States, the Virginia Medicaid rates are 17% above the national rate for the Medicaid population.

Figure 5. Timely Initiation of Prenatal Care—Benchmark Comparisons
Source: Prenatal Care Clinical Study, 2003



Timely Receipt of Immunizations

Standard of care guidelines for childhood immunizations have been endorsed by all the leading professional organizations, including the Advisory Committee on Immunization Practices, the American Academy of Pediatrics' Committee on Infectious Diseases, and the American Academy of Family Physicians. Additionally, immunization performance is a key element of HEDIS and a standard quality of care measure emphasized in both national and state Healthy People 2010 programs. Compliance with this standard of care is strongly associated with a reduction in preventable disease rates and associated costs, both human and financial. As a result, DMAS has set a goal of 85% for up-to-date immunizations for children at 24 months. For the fourth year, a special study was conducted to assess overall compliance with this goal for each of the Medicaid delivery systems (MEDALLION, Medallion II, and Fee-For-Service) and the FAMIS program.

The compliance rates for the selected immunizations for the overall non-FAMIS Medicaid population as well as each of the Medicaid delivery systems are presented in Table 7. In general, MEDALLION and Medallion II rates are similar for most indicators and meet or exceed the 85% goal. However, for DTP, HBV, and Hib, the MEDALLION program outperformed Medallion II by 4% to 10%. Immunization rates for Fee-For-

Service trail the Medallion programs for all but one measure and only met or exceeded the 85% goal for HBV, MMR, and VZV.

Table 7. Medicaid Results by Immunization Series (Source: Immunization Status at 24 Months, SFY 2002)

Immunization Series	Total Medicaid	MEDALLION	Medallion II	Fee-For-Service
DTP	88%	93%	89%	80%
HBV	87%	93%	83%	85%
Hib	85%	90%	85%	80%
MMR	91%	92%	94%	88%
OPV	89%	93%	91%	83%
VZV	91%	92%	91%	89%
4:3:1	84%	86%	86%	77%

While opportunities for improvement exist for Virginia's Medicaid delivery system, aggregate rates of compliance with these indicators are consistent with or above the immunization rates of the U.S. and Virginia general populations and are well above the levels of the U.S. Medicaid population. These comparisons are presented in Table 8.

Table 8. Percentage of Cases Reported as Up-to-Date for Several Immunization Series for Benchmark Comparisons (Source: Immunization Status at 24 Months, SFY 2002)

Immunization Series	U.S. General	Virginia General	U.S. Medicaid	Virginia Medicaid
DTP	80%	77%	69%	88%
HBV	89%	87%	73%	87%
Hib	67%	94%	74%	85%
MMR	90%	87%	82%	91%
OPV	88%	86%	76%	89%
VZV	74%	79%	67%	91%
4:3:1	76%	74%	N/A	84%

In addition to these favorable comparisons with established benchmarks, overall study findings demonstrated that compliance rates from SFY 1998 through SFY 2002 increased moderately, with all of the immunization indicators (except the 4:3:1 combined series) at or above 85%. The 4:3:1 combined series was only slightly

below at 84%. This achievement is particularly remarkable in light of a shortage in some vaccinations from 2000 to 2002. It is apparent that immunization compliance has become a high priority within these delivery systems.

Timeliness of Initial Appointments for Children

Findings from the CAHPS® survey support the high level of immunization compliance among Medicaid enrollees. Ninety percent (90%) or more of all respondents reported that they received an initial appointment for their child for check-ups, shots, or drops as soon as they wanted. Furthermore, 69% or more of enrollees reported receiving well child reminders. Ninety percent (90%) of FAMIS PCCM enrollees recalled receiving well child reminders, which is a significant increase over 2001 when the rate was only 53%. Table 9 provides a summary of these findings.

Table 9. Percentage Receiving Well Child Appointment when Wanted and Well Child Reminders (Source: CAHPS® Survey 2003)

	Received initial appt. for child when wanted	Received well child reminders
MEDALLION	92%	70%
FAMIS PCCM	100%	90%
Medallion II	98%	76%
FAMIS MCO	90%	69%

Appointment Wait Times

CAHPS® survey respondents reported average wait times for appointments between 2.8 and 5 days. This is well below the DMAS contractual standard that requires appointments for routine care to be made within 30 calendar days of the enrollee's request. Table 10 provides the average wait time for an appointment for each of the respondent categories.

Table 10. Average Appointment Wait Times in Days (Source: CAHPS® Survey 2003)

Average Appointment Wait Times in Days	
MEDALLION Adult	5
MEDALLION Child	2.8
FAMIS PCCM	4
Medallion II Child	4
FAMIS MCO	3.7
Medallion II Adult	Not reported

Opportunities for Improvement

Getting Care Quickly

The 2003 composite score for all CAHPS® survey respondents indicates some possible issues with getting care quickly. One-third (33%)of respondents from the adult MEDALLION survey said they never or only sometimes receive care quickly. This score exceeds both the adult Medicaid (28%) and commercial (21%) benchmarks for this measure as reported by the National CAHPS® Benchmarking Database 2003 as well as the Medallion II adult score at 27%. The greatest area of dissatisfaction for MEDALLION and Medallion II respondents appears related to wait times at their doctor's office. Nearly 64% of MEDALLION adult respondents reported that they never or only sometimes were taken to the exam room within 15 minutes of their appointment. Similarly, 55% of Medallion II adult respondents indicated dissatisfaction with office waiting times. Additionally, over 20% of MEDALLION adult respondents reported dissatisfaction with receiving needed help or advice when calling during regular office hours; receiving care for an illness, injury, or condition as soon as they wanted; or receiving an appointment for health care as soon as they wanted.

Child survey respondents also indicated issues with receiving care quickly, with composite scores of 23% for MEDALLION and 25% for Medallion II enrollees. Respondent dissatisfaction was related primarily to exam room wait times. Similar to adult respondents, 53% of MEDALLION and 55% of Medallion II enrollees reported that their children were never or only sometimes taken into an exam room within fifteen minutes of their appointment time. Additionally, FAMIS PCCM and MCO enrollees expressed high levels of dissatisfaction with this same aspect of care. Table 11 displays dissatisfaction scores for all respondent categories for exam room wait time. Opportunities clearly exist for improvement in exam room wait times for both delivery systems.

Table 11. Percent Dissatisfaction with Exam Room Wait Times (Source: CAHPS® Survey 2003)

Dissatisfaction with Exam Room Wait Times	
MEDALLION Adult	64%
MEDALLION Child	53%
FAMIS PCCM	46%
Medallion II Adult	55%
Medallion II Child	55%
FAMIS MCO	53%
MEDALLION Adult	64%

Timeliness of Urgent Care for MEDALLION Adults

MEDALLION respondents to the Adult CAHPS® survey reported a much higher utilization of the emergency room in 2003 than in 2001. Forty-six percent of MEDALLION as compared to 26% of Medallion II enrollees reported at least one visit to the emergency room in the past six months in 2003, while only 38% of MEDALLION respondents sought emergency care during a similar period in the 2001 survey. This increase does not appear to be an access issue based upon stability in the percentage of enrollees who had doctor visits in the last six months and the average number of visits from 2001 to 2003. Additionally, the average wait time between making an appointment and seeing a doctor was only 5 days. This may, however, indicate a problem with enrollees receiving timely care for urgent conditions. Enrollees who reported needing care right away waited an average of 2.2 days for an appointment, which is beyond the urgent care standard of 24 hours contractually required by DMAS. Emergency room visits were slightly above 2001 reported levels for MEDALLION child survey respondents; however, Medallion II child survey respondents reported a 4% decrease in emergency room utilization. The average number of doctor visits within six months for both groups was reported at 2.2. Table 12 displays the percentage of enrollees who reported needing care right away and the average wait time for an appointment.

Table 12. Percentage Needing Care Right Away and Average Wait Time (Source: CAHPS® Survey 2003)

	Needed care right away	Average days wait time
MEDALLION Adult	57%	5 days
MEDALLION Child	43%	2.8 days
FAMIS PCCM	44%	4 days
Medallion II Adult	60%	Not reported
Medallion II Child	34%	4 days
FAMIS MCO	31%	3.7 days

To address the enrollee perceived barriers surrounding wait times; DMAS and their contractual MCOs might consider implementing a series of reminders in newsletters to educate the front line providers and office staff on the contractual requirements for urgent care delivery. In addition, MCOs could remind enrollees to call their grievance centers to report delays in receiving urgent and emergent care, so that quality of care and service issues could be investigated in a timely matter. All of the educational interventions should be delivered according to language and literacy specifications set forth in the DMAS contract.

Section IV – Quality AT A GLANCE

Although access and timeliness are essential components of a quality-driven system of care, there are separate indicators that serve as direct and proximate measures of the quality of care and services provided to Medicaid enrollees. Outcome data from clinical studies performed by Delmarva support the delivery of quality health care to the Medicaid population. Equally important are enrollees' perceptions of the quality of care they receive, which are closely related to their satisfaction with providers and overall health care services. Several items from the CAHPS® survey that reflect enrollees' experiences with health care delivery are examined to complete this assessment. In addition, information from the Prenatal Clinical Care Study and MCO Quality Review results were added to provide more an insight into strengths and opportunities for system improvement.

Strengths

Satisfaction with Overall MCO

Perhaps the most revealing data on the quality of the Medicaid delivery systems are found in enrollees' responses to the CAHPS® survey item of overall rating of MCO. Consumer responses in 2002 Adult CAHPS reports showed a high level of overall MCO satisfaction, which was a statistically significant improvement over the National CAHPS Benchmarking Database that contains national Medicaid and commercial benchmarks.

Average Rating of Health Care Overall Remains High

In addition to high levels of satisfaction with their MCO, enrollees' average rating of their health care overall was extremely high as illustrated in Table 13. On a 10-point scale, with "10" being the highest score, average scores were close to "9" for most respondent categories.

Table 13. Average Rating of Health Care Overall (Source: CAHPS® Survey 2003)

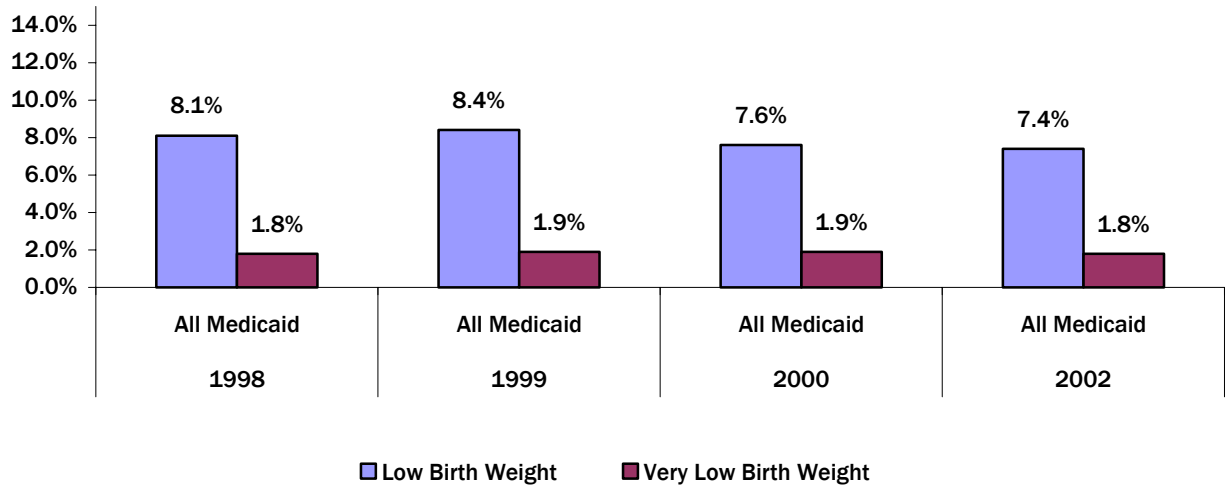
Average Rating of Health Care Overall	
MEDALLION Adult	8.2
MEDALLION Child	8.8
FAMIS PCCM	8.7
Medallion II Child	8.7
FAMIS MCO	8.8

A review of the 2003 Medallion II Adult CAHPS report shows that the Medallion II respondents rated their MCO statistically higher than the National Adult Medicaid plan distribution. Of the case mix adjusted responses, 53% of Medallion II adults rated their MCO a 9 - 10 on a scale of zero – 10.

Birth Weight Outcomes Continue to Improve

Quality prenatal care has been shown to have a positive impact on the prevention of complications and premature deliveries. Based upon Delmarva's follow-up study of prenatal care, Virginia continues to see a decrease in the percentage of infants in Medicaid born with low or very low birth weight. Results for Virginia Medicaid birth weight outcomes for SFY 1998–2002 are displayed in Figure 6. For SFY 2002 low birth weight rates for the Virginia Medicaid population are marginally lower at 7.4% in comparison to national and statewide benchmarks. According to the March of Dimes, low birth rates were 7.6% and 7.8% for the U.S. general and Virginia statewide populations for this same time. Only minimal differences were found to exist between Fee-For-Service, MEDALLION, and Medallion II enrollees.

Figure 6. Trends in Low and Very Low Birth Weight Rates
Source: Prenatal Care Clinical Study 2003



MCO Systems Have Quality Structure and Processes in Place

Evaluation of each MCO's internal quality management structure and processes is critical in ensuring that a strong foundation exists to support a quality-driven system of care. Each MCO was reviewed against a set of quality management standards that address program components such as the quality improvement program description and studies, provider cooperation with quality studies, coordination and continuity of care, and coordination of quality improvement activities with other management activities. Generally, the MCOs performed extremely well on most elements, with two of the MCOs demonstrating improvement over the

2002 scores. All MCOs have comprehensive written quality management program descriptions that include HEDIS, CAHPS®, and other study results. Generally, there was evidence of focused quality improvement activities for outcomes below benchmark, goal, or target with assignment of corrective action plans to a staff person responsible for improvement. Each MCO had at least two quality improvement studies as required by DMAS. Provider cooperation with quality studies was a strength identified for all MCOs. Each of the MCOs had policies and procedures to support coordination and continuity of care, including provisions for an enrollee to retain assignment to a terminated practitioner. Quality improvement committee meeting minutes demonstrated effective coordination of quality improvement activities with other management activities. Additionally, a system for monitoring enrollee grievances and identifying opportunities for improvement was in place at all MCOs.

MCO Utilization Management Systems Shows Considerable Improvement

Utilization management (UM) provides the MCO with the opportunity to monitor the appropriateness of provider practices so that cost-efficient, as well as quality-enhancing, best practices are followed. In addition, care coordination and support for at-risk enrollees are monitored to ensure that those requiring health care are provided services in a timely manner. In assessing the effectiveness of MCO systems for UM, three distinct elements were reviewed during the calendar year (CY) 2002 onsite quality review. The elements included specific components of the MCO's written UM program description, specific UM policies and procedures, and review of UM case documentation. In general, MCOs had a comprehensive written UM program description supported by policies and procedures that outlined the process and time frames for evaluating medical necessity, the criteria used, the sources for obtaining medical information, and physician responsibility for all adverse determinations. New and existing MCO staff are trained on medical necessity criteria and evaluated on the proper application. There are mechanisms to identify areas of over- and underutilization and a process for implementing and monitoring corrective action as indicated. In the follow-up 2003 desktop review of components requiring corrective action, most MCOs performed well. One MCO, in particular, demonstrated considerable improvement from 2002.

MCO Systems to Address and Monitor Grievances are Adequate

To ensure that the MCO has effective systems in place to respond and manage grievances and appeals, Delmarva reviewed written policies and procedures, tracking systems, and case files. In general, all MCOs demonstrated effective procedures for communicating enrollees' right to file a formal grievance, complying with required notification and time frame requirements for processing grievances and communicating determinations. Grievance logs contained all required documentation, and a process for notifying DMAS of grievance receipt and determination within required time frames was evident. Additionally, the complaint monitoring system within each MCO supported identification of opportunities for improvement.

Opportunities for Improvement

Continuity of Care and Satisfaction with Personal Doctor and Specialists

Results from the 2003 CAHPS® survey for all but one respondent category indicate an increase over 2001 in the number of enrollees that reported a new personal doctor or nurse since they joined the MCO. Additionally, three respondent categories evidenced a decrease in the average satisfaction rating of their doctor. Average satisfaction ratings with specialists similarly decreased in 2003 for four categories of respondents. Each of these measures can potentially impact quality of care. Continuity of care becomes especially challenging whenever a transfer is required to a new care provider. Furthermore, decreased satisfaction with the new provider may be a by-product of this change and the associated difficulty in forging new relationships. Absence of a long-term relationship with a trusted provider may present barriers to seeking necessary care and increase the likelihood of patient non-compliance with treatment recommendations. Table 14 provides comparisons between 2001 and 2003 CAHPS® results for each of these survey items.

Table 14. New Personal Doctor and Rating of Doctor and Specialist (Source: CAHPS® Survey 2003)

Survey Subpopulation	New Personal Doctor/Nurse		Average Rating of Doctor		Average Rating of Specialist	
	2001	2003	2001	2003	2001	2003
MEDALLION Adult	41%	58%	8.8	8.4	9.0	8.2
MEDALLION Child	31%	46%	9.0	8.8	9.0	8.6
FAMIS PCCM	26%	19%	8.8	8.8	8.4	8.4
Medallion II Child	27%	33%	8.8	8.7	8.7	8.1
FAMIS MCO	32%	39%	8.7	8.8	8.6	8.2

Improved Documentation of Quality Improvement Studies

While improvement was evident in better documentation of quality improvement study design and related interventions since the 2002 onsite review, there are still MCOs that struggle with compliance. Challenging areas include missing or inadequate documentation to support consideration of multiple factors in selecting an area for study. In addition, MCOs struggle with the development of objective, clear, and unambiguously defined indicators. Denominators are often ill defined and fail to reflect a representative and generalizable sample. Benchmarks or goals as well as plans for real improvement over baseline measures were not always present. Documentation was often lacking that would allow for tracking of study progress from beginning to end. Clearly, several opportunities for improvement exist in both study design and documentation.

Utilization Review Case Documentation

Three components concerning utilization review case documentation were assessed as partially compliant during the CY 2002 review. For the 2003 desktop review, these elements remained unchanged since the MCOs did not submit any actual case documentation for review. Similarly, because the initial review for the newly contracted MCO was not performed, onsite compliance with these elements could not be assessed. Table 15 identifies the specific areas where case documentation requirements have not been fully met.

Table 15. Utilization Review Case Documentation (Source: Virginia DMAS EQR Final Report CY 2002)

Elements of UR Case Documentation	Compliance			
	Met	Partially Met	Not Met	N/A
Evaluation and documentation of medical necessity based on review criteria	1	3		1
Evaluation and documentation by appropriately licensed staff	1	3		1
Review completed and decision communicated to provider and enrollee within 1 day of receipt of medical information	1	3		1

Enrollee and DMAS Appeals Notification

Opportunities exist for improvement in describing the appeals process for enrollees that are notified of an adverse decision. DMAS has outlined required content to be included in each notification. Additionally, MCO tracking of the time frame for notification to and verification of DMAS receipt of information was not consistently met by the MCOs.

Section V – Recommendations

This annual report provides a review of recent studies conducted by Delmarva as the EQRO to assess the progress that Medicaid managed care systems have made in fulfilling the goals of DMAS and the requirements of their contracts. Strengths and opportunities for improvement were derived from an in-depth review of each study and evaluated against three essential performance areas for quality-driven managed care systems: appropriate access to and timeliness of quality care and services. The purpose of this section is to offer DMAS a set of recommendations to build upon the strengths and to address the areas of concern for the existing programs. These recommendations are independent of those included in each study but draw from the findings of those studies individually and in the aggregate.

Intensify Review of ER Utilization Data on MEDALLION and Medallion II Adult Enrollees

Results for adult respondents to the CAHPS® survey indicated that emergency room utilization increased substantially from 2001 to 2003 despite the percentage of enrollees receiving an average of four doctor visits over a six-month period remaining unchanged. Based upon other survey responses, this increased utilization may perhaps be explained by a sicker population and/or potential barriers to urgent care access. In 2003, 64% of adult MEDALLION enrollees reported calling their doctor's office during regular office hours for help or advice as compared to 58% in 2001. Additionally, 57% of adult respondents reported that they had an illness, injury, or condition that needed care right away in 2003 compared with 40% in 2001, a statistically significant increase. The average reported wait time for a doctor appointment when the enrollee needed care right away was 2.2 days. If urgent care was in fact required, this wait time exceeds the DMAS contractual requirement that urgent care enrollees are to be seen by a doctor within 24 hours. It is recommended that further analysis of emergency room utilization be undertaken to better understand the health care needs of this population, with a focus on diagnoses, provider, and level of care as well as time of service. More effective use of case and/or disease managers may help MEDALLION Adult enrollees in better managing chronic conditions, reducing the likelihood of emergency room visits. It is also recommended that providers be reminded of the urgent care standard for appointment scheduling. While after-hours access to a provider appears high based on findings from the 24/7 Access Study, continued improvement in accuracy of provider phone numbers and emergency contact information may facilitate enrollees receiving care within the appropriate setting and time frame based upon the level of urgency.

Develop Specific Interventions to Address Dissatisfaction with Exam Room Wait Times

The 2003 CAHPS® composite score for the getting care quickly domain reflects considerable dissatisfaction among adult and child survey respondents. This dissatisfaction exceeds both Medicaid and commercial CAHPS® benchmarks. Of the four separate measures related to this domain, the greatest level of dissatisfaction appears to be with exam room wait times. The development of MCO focused interventions in this area could have a significant impact on composite scores in subsequent surveys. It is recommended that DMAS and the MCOs communicate this finding to participating providers in both the MEDALLION and Medallion II programs. Another recommendation might be to encourage the MCOs to monitor complaint data for trends related to specific providers. Where a provider-specific trend is identified, contact with the individual office could be made to request a corrective action plan to address this opportunity for improvement. In addition, focus groups held with enrollees and providers might serve to investigate the root cause of the perceived delays, and to establish a baseline for discussion with provider offices.

Possible Access Delays While Waiting for MCO Approval of Care/Services

Aggregate results from the Medallion II adult CAHPS® survey suggest a much higher percentage of enrollees dissatisfied with delays in health care attributed to MCO approval of care and services. Individual MCO scores range from 28% to 43%, which indicate access barriers due to delays in health care while awaiting MCO approval for care and services. Compliance with the contractual requirement stipulating notification of providers and enrollees of UR decisions within one day of receipt of medical information is low, which might have led to increase dissatisfaction. Further analysis of this outcome data is recommended to understand the factor(s) driving the lower level of satisfaction. Contributing factors could include MCO turnaround times for authorizations and/or enrollees and providers or enrollee lack of understanding of the need for pre-authorization for certain services. DMAS might also consider surveying the providers to identify additional areas of education.

Develop Specific Minority Racial/Ethnic Outreach Activities to Improve Access and Quality to Enrollees

Results from the CAHPS® survey indicate that respondents to the child survey had good recall of reminder notices sent for well child visits. This may be a significant contributing factor to the high level of immunization rates among children at age 2. The MCOs have demonstrated that they have begun outreach to adult enrollees on general preventive and condition-specific services, however it may be time to be more proactive – to develop culturally sensitive materials that have the potential to increase compliance, improve quality of life, and decrease associated chronic care costs in the African American, Asian, and Hispanic populations. We recommend that the MCOs continue to use consumer advisory councils that include a broad representation from the Medicaid populations served in different regions to lend guidance in the development of effective materials. Ongoing training in cultural competency should be required of MCO staff as well as to contracted providers to increase the likelihood that plans of care and expected outcomes developed will achieve their intended goals. Because 90% of women included in the Prenatal Clinical Care

Study were newly eligible for Medicaid, developing effective strategies to communicate the availability of Medicaid services may facilitate earlier prenatal care.

Convene African American Prenatal Quality Improvement Collaborative to Address Low Birth Weights

The Prenatal Clinical Care Study identified pregnant African American women as being almost twice as likely as other groups to have a low birth weight baby. This difference exists even when higher levels of prenatal care have been received. Since low birth weight babies have complications that often lead to chronic health conditions throughout their lives, this presents an opportunity to increase the quality of life of these infants and reduce health expenditures arising from neonatal intensive care services and ongoing treatment for chronic illnesses or conditions associated with premature deliveries. It is therefore recommended that DMAS consider initiating a collaborative between interested MCOs and community stakeholders to share data and knowledge that promotes an understanding of the differences between Virginia's African American women who had normal weight babies and those who had low birth weight babies. DMAS has already had a successful collaborative with one contracted MCO to explore barriers to care in African American women who have diabetes; therefore, they could apply the same successful formula to this initiative.

Convene Medallion II Taskforce to Study and Address Frequent PCP Changes

The number of Medicaid enrollees required to change personal doctors since enrolling in one of the managed care delivery systems increased significantly from 2001 as evidenced by findings from the 2003 CAHPS® survey. Some of this change may be attributed to the late 2001 expansion of Medallion II into 48 additional localities. Retention of historic providers within the managed care delivery systems may also be a contributing factor. Because provider transitions can potentially impact continuity of care and services for Medicaid enrollees, it is recommended that the Medallion II MCOs convene to discuss this common issue, and to conduct a barrier analysis activity to develop action plans that address potential disruptions of quality care and services.

Conduct an Independent Provider Satisfaction Survey

Provider satisfaction surveys are routinely conducted in any managed care delivery system, because providers are essential partners in the provision of accessible, high-quality care delivered to enrollees. In addition to assessing enrollee satisfaction, DMAS may want to consider conducting a provider satisfaction survey. This can serve as an early warning system of emerging issues that could negatively impact provider participation and facilitate DMAS' work with the managed care delivery systems to proactively develop effective retention strategies. As recommended in previous sections, provider satisfaction surveys present additional benefits in either confirming enrollees' perception of health care delivery or surfacing areas for further analysis where significant disparities in responses exist.

Further Analysis of CAHPS® Survey Results

DMAS may want to explore the feasibility of a more in-depth analysis of CAHPS® data to develop an increased understanding of the relationship between responses to individual survey items and demographics of survey participants to facilitate targeted interventions. For example, knowledge of the relationship of race/ethnicity of survey respondents to scores of health care literacy may help in identifying opportunities for enhancing communication and access in certain groups.

Existing Provider Office Hours Could Cause Access Issues

CAHPS® survey results suggest that time frames for routine appointments are within 5 days, which is well below the DMAS contractual standard of 30 days. Despite this exceptional performance, respondent scores for the survey item related to getting an appointment as soon as they wanted ranged from only 47% to 62%. These low scores may an indication of dissatisfaction with difficulty in scheduling an appointment outside of normal office hours. DMAS may want to conduct additional research to explore the possibility of evening and weekend office hours within certain managed care networks. If results suggest potential access issues in a particular region, DMAS may want to consider establishing minimum standards for appointment availability outside of routine office hours, such as one evening and Saturday at least once or twice a month.

Continue Comparative Analysis of All Delivery Systems

With the 2001 expansion of the Medallion II program and the modification of the CMS waiver to allow concurrent operation of both managed care delivery systems in these new localities, DMAS has a unique opportunity to conduct comparative studies of each population group. This would facilitate increased understanding of the demographics of each system's enrollees, the factors influencing selection of each delivery system, utilization patterns, and clinical and service outcomes. This may also present additional opportunities to identify best practices.

Delmarva stands poised to support DMAS in meeting their federal requirements set forth in the area of external quality review, and is ready to provide technical assistance so the State develops their quality strategies for FY 2003.

Section VI – References

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3. *Commonwealth of Virginia Department of Medical Assistance Services Medallion II Managed Care Contract,* Department of Medical Assistance Services, July 1, 2002

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6. *The Department of Medical Assistance Services Managed Care*, www.dmas.state.va.us, May 2002

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10. *Collins K, et al, Diverse Communities, Common Concerns: Assess Health Care Quality for Minority Americans.* Findings from The Commonwealth Fund 2001 Health Care Quality Survey. The Commonwealth Fund, 2002.

11. *The Health Employer Data and Information Set (HEDIS®)* is a nationally recognized benchmark for health plan performance compiled by the National Committee for Quality Assurance. Data reported here are for CY 2002.

12. *March of Dimes* data are drawn from their 2003 report, but based on data from CY 2000. Delmarva data based on SFY 2002.

Appendix A – 2002 Prenatal Study

Findings

Major findings are summarized in the bullet points shown below. These findings as well as additional and more detailed results are shown in a series of tables and figures contained in Section Two.

- The majority of women (77%) in Medicaid who gave birth in SFY 2002 began prenatal care in the first trimester of pregnancy. This compares to 78% in SFY 2000.
- The majority of women (90%) in Medicaid who gave birth in SFY 2002 were newly eligible for Medicaid due to pregnancy and 66% of women newly enrolled had a start of prenatal care date that came before their application date.
- Fewer women in the FFS program began prenatal care in the first trimester and received the expected number of prenatal care visits compared with women in the managed care programs. Differences between these programs are virtually identical to those observed in SFY 2000.
- Seventy-one percent of women in FFS, who became Medicaid eligible because of pregnancy, were determined eligible for Medicaid in the third trimester of pregnancy. These women received retroactive eligibility to Medicaid, which covered their care from conception or for three months prior to their application date, whichever came later. This represents a 6% increase from SFY 2000.
- Forty-two percent of women in MEDALLION, who became Medicaid eligible because of pregnancy, were in the third trimester when they were enrolled in the MEDALLION program. The percentage enrolled in MEDALLION prior to the third semester increased from 47% in SFY 2000 to 58% in SFY 2002.
- Forty-nine percent of women in Medallion II, who became Medicaid eligible because of pregnancy, were in the third trimester when they were enrolled in an MCO. This percentage dropped from 58% in SFY 2000.
- Twenty-five percent of women enrolled in FFS were age 30 and above. This is a higher percentage than observed in the MEDALLION and Medallion II programs. The percentage of women in FFS between the ages of 20 and 29 (56% in FFS vs. 65-68%) was lower than in MEDALLION or Medallion II.
- As compared with white women, African-American, Asian, and Hispanic women tended to initiate care later in pregnancy and have fewer visits once care was initiated, but only African-American women had a higher percentage of low and very low birth weight babies. Disparities between whites and African-American women remained constant from SFY 2000, but the percentage of births to white women

decreased while the percentage born to African-American women remained constant and the percentage born to other minorities increased.

- The rate of low and very low birth weight for infants was highest for women in the FFS program. These percentages are essentially unchanged from two years ago.

Conclusions and Recommendations

- The majority of women enrolled in Medicaid who delivered babies was newly eligible for Medicaid due to pregnancy and started prenatal care before applying for Medicaid. Therefore, we recommend developing approaches that will publicize the availability of Medicaid for eligible women so that a higher percentage can begin appropriate prenatal care in their first trimester.
- A higher proportion of women in FFS who were not new to Medicaid were African American and age 19 and under. Hispanic women were also highly represented in the FFS program. We recommend further study to identify the reasons why these populations are less likely to enter the MEDALLION and Medallion II programs. We also recommend that additional targeted efforts be made to improve the early start of prenatal care for these populations.
- A higher percentage of women in managed care received the expected number of prenatal care visits and had lower rates of poor birth outcomes. While women appear to be entering these programs earlier than in the past, we recommend continued efforts to enroll pregnant women even earlier in these programs. Success in this effort may increase the adequacy of prenatal care and result in better birth outcomes.

Appendix B – 2003 24/7 Access Study

Results

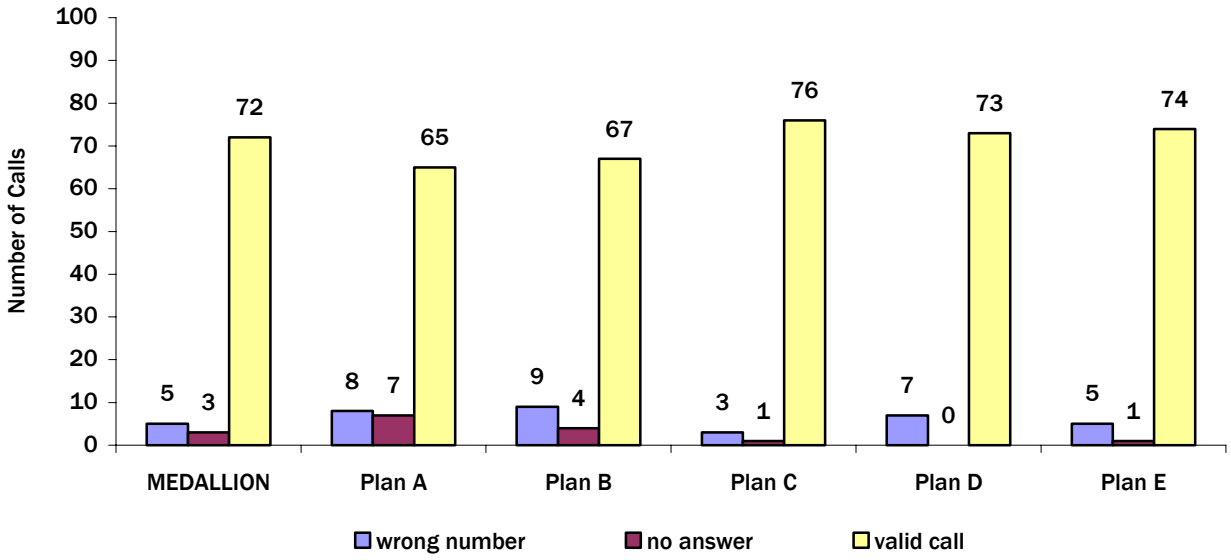
Emergency Contact

A first purpose of the study was to determine whether participants in the MEDALLION and Medallion II programs could obtain emergency assistance from their physicians. Such assistance presumes that the provider has a valid phone number that is answered in a reasonable period of time (i.e. six rings or less). The phone number for each sampled provider was dialed and an initial determination was made concerning whether the number was valid. Figure B1 compares the initial disposition of calls made during the 2002 and 2003 surveys.

Figure B1. Providers with Valid, Answered Phone Numbers

Providers sampled from both MEDALLION and Medallion II were reached more frequently in the 2003 Survey than they were in 2002. Ninety percent of providers in the MEDALLION sample and 89% of those in the Medallion II sample had valid phone numbers that were answered within six rings While MCO-specific information was not available in 2002, Figure B2 shows the percentage of valid calls for MEDALLION and each MCO participating in the Medallion II program, along with the reasons calls were invalid. Overall, in the 2003 sample, 8% of calls did not reach the physician's number and 3% were not answered within six rings.

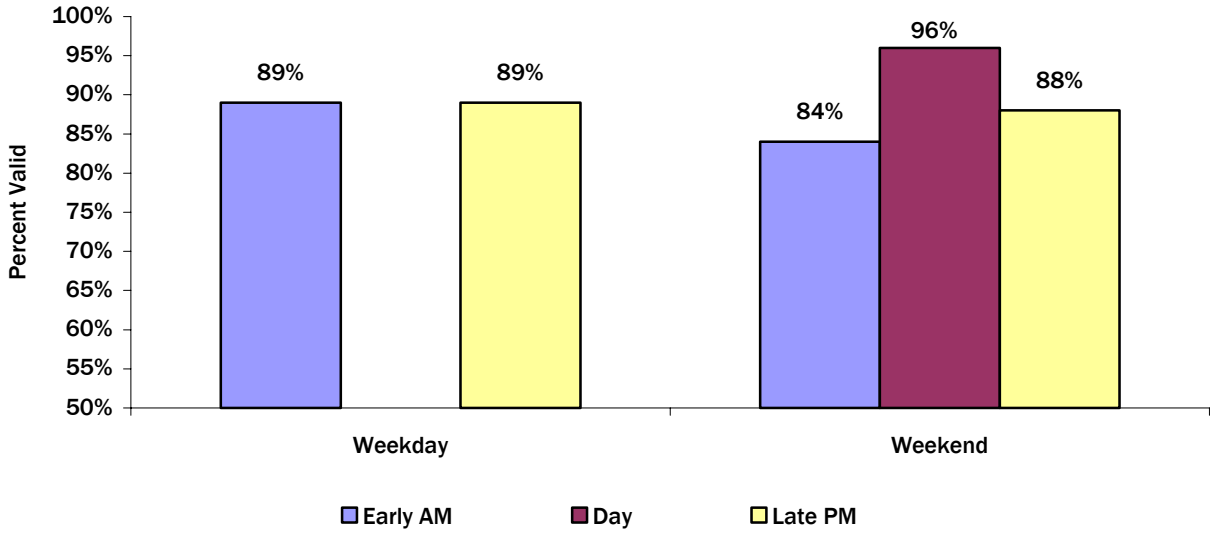
Figure B2. Number of Valid Calls for Each Plan's 2003 Sample



The CY 2002 report identified the need to improve the accuracy of numbers available in the provider database. Results from this year's study reflect substantial improvement in this area. Only 10% of calls did not reach the desired provider, compared to 30% a year ago. While this trend is very encouraging, further improvement can still occur so that participants in these plans can obtain access to emergency assistance from their physicians. Because participants who cannot reach their providers may be more likely to seek care in emergency rooms, continued reductions in inaccurate phone information may be very cost effective for the Commonwealth's Medicaid program.

As a follow-up to this analysis we compared the ability to reach providers across the time periods during which calls were placed. Figure B3 shows the results of this comparison. While 95% of calls made on weekends during the day were valid, the difference in the percentage of calls in other time periods was not statistically significant. As a result, it does not appear that there is a particular time period that can be focused on to improve after-hours access to providers.

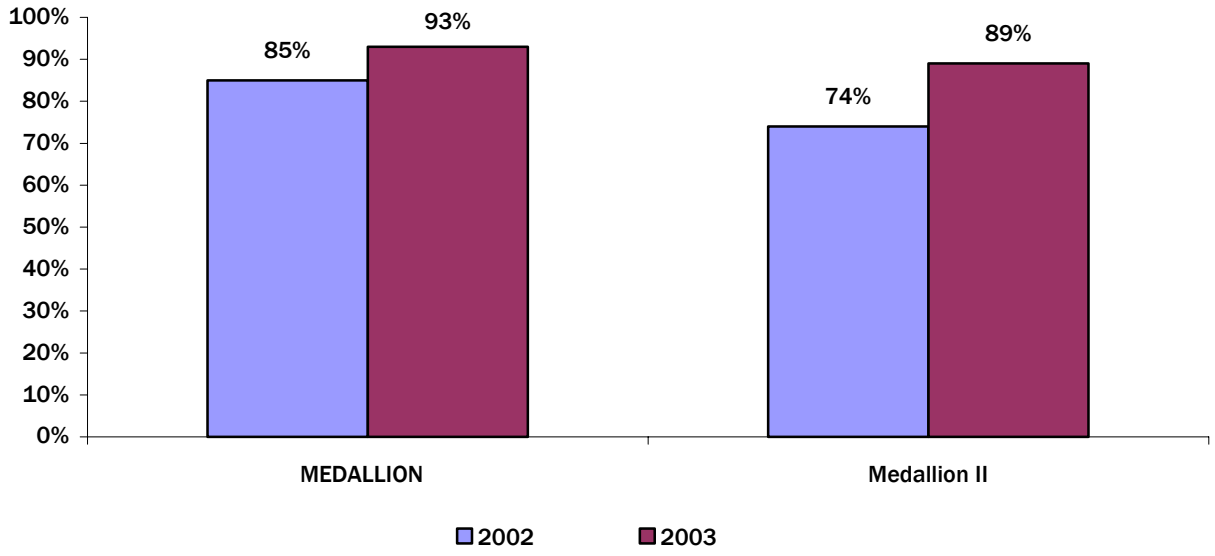
Figure B3. Percentage of Valid Calls by Time Period



We also compared the percentage of valid numbers reached in each of the three largest specialty groups. While 94% of pediatricians had valid numbers, compared to 89% of those in family practice and 86% of those in internal medicine, there is insufficient evidence to conclude that some specialties have a significantly higher percentage of invalid phone numbers than others do.

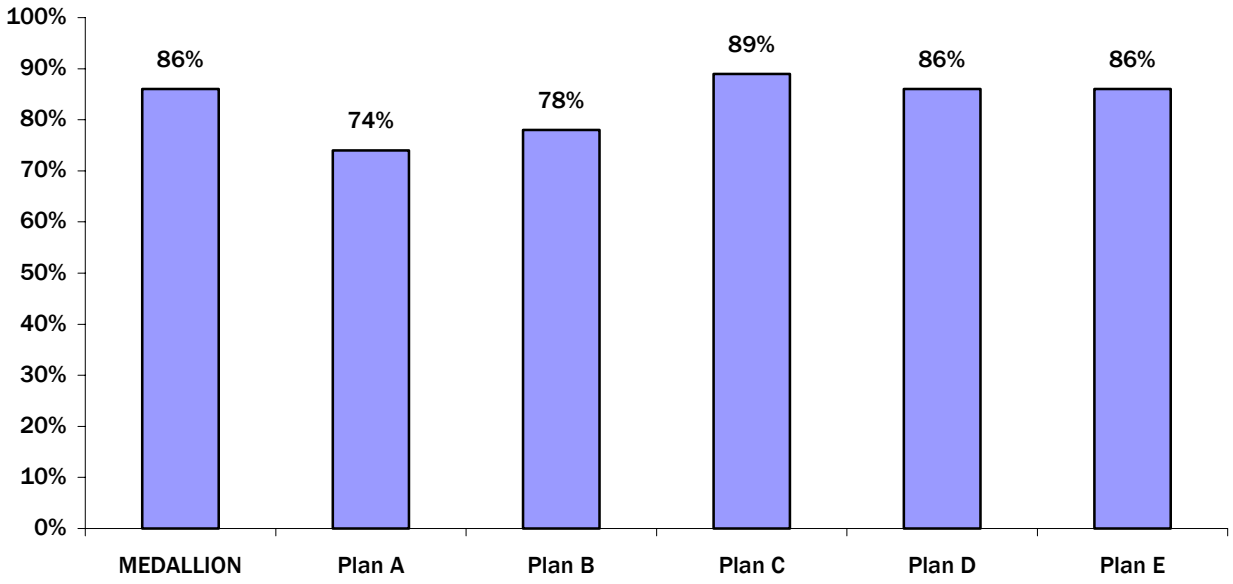
Even if a phone number for the physician is valid and answered, emergency contact information may still be unavailable. Sometimes these numbers reached answering machines while in other cases a member of the physician's office staff or an answering service answered the phone. While answering services and the physician's office staff represent an emergency contact, we examined the answering machine messages to determine whether they provided needed information regarding whom to call or how to access services in an emergency. Ninety percent of all answering machines provided this information. Differences between MEDALLION (93%) and all MCOs within Medallion II were less than 6% and probably reflect random sampling error. When we compared these percentages to the results from last year's survey, improvement was observed for both the MEDALLION and Medallion II programs. As shown in Figure B4, the percentage of answering machines with emergency contact information increased by 8% for MEDALLION providers and 15% for providers in Medallion II.

Figure B4. Percent of Answering Machines with Emergency Contact Information



One final analysis was performed to determine the overall percentage of provider phone numbers that provided emergency contact information. We calculated this percentage by dividing the number of valid calls that reached either an answering machine that provided emergency contact information or a representative from the physician's office or answering service by the total number of calls. Results are reported in Figure B5, and reflect very little difference across MEDALLION and Medallion II plans.

Figure B5. Percent of calls that were valid and had emergency Information

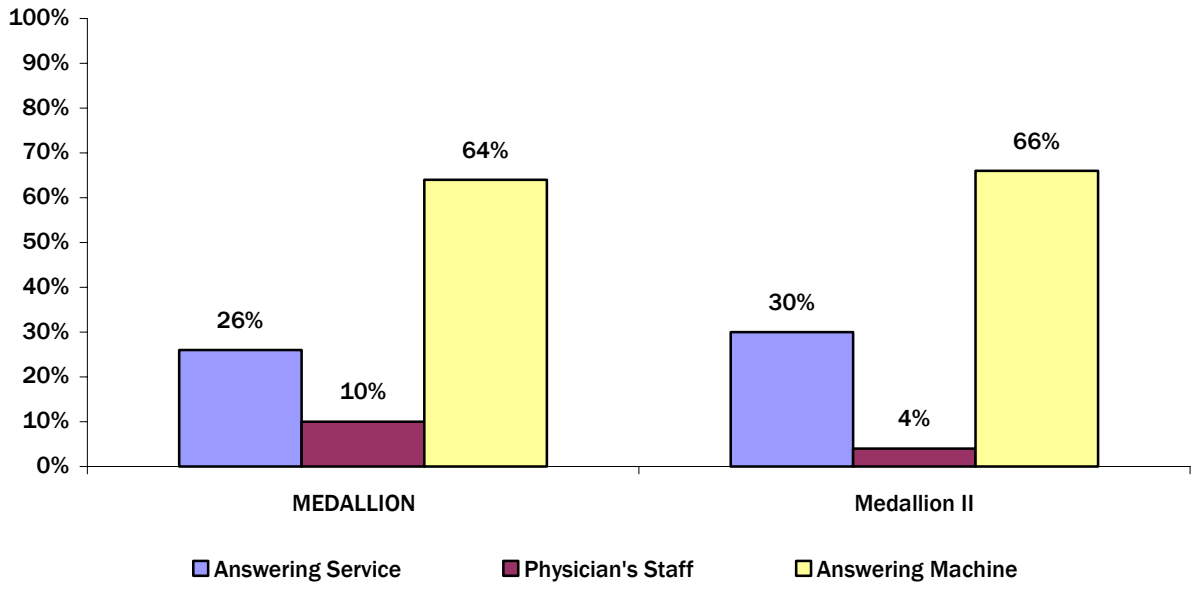


Overall, these numbers reflect little difference in the availability of emergency contact information to participants in MEDALLION or any of the Medallion II MCOs. Because many providers participate in several Medallion II MCOs and some affiliate with MEDALLION and one or more MCOs, similarities in plans' rates are almost inevitable. The list of providers for each plan that were not valid or lacked emergency contact information is provided in Appendix A.

Type of Contact

A second purpose of the study was to describe who was reached when a valid phone call was completed. Figure B6 reports the percentages of calls to MEDALLION and Medallion II providers that reached an answering machine, a member of the physician's office staff, or an answering service.

Figure B6. Percent of Valid Calls by Response Type

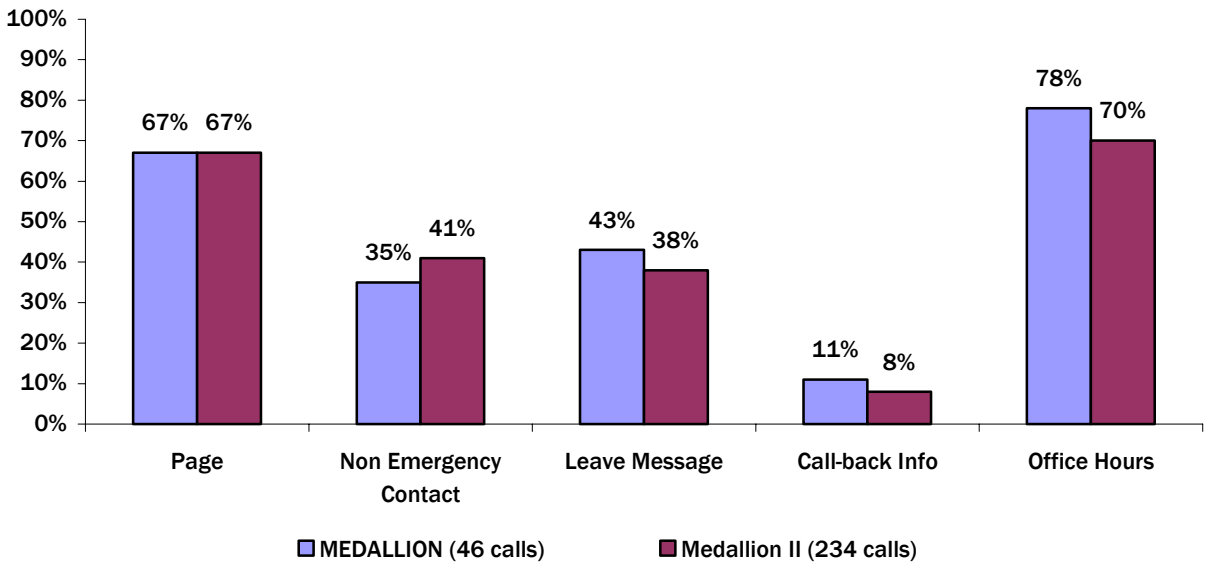


Roughly, two-thirds of all calls in both MEDALLION and Medallion II reached an answering machine while less than 10% of calls to either program reached physicians' office staff. These percentages differ considerably from those reported in last year's study, when substantially more calls reached office staff. However, these differences are because last year's study made calls on weekdays during office hours, while this year's study did not.

Answering Machine Information

A third goal of this year's study was to describe the types of information provided on physician's answering machines. Because two-thirds of all calls on weekends and between 7pm and 7am reach an answering machine, understanding the content of these messages is important to efforts to evaluate resources made available to plan or program participants. Figure B7 compares MEDALLION and Medallion II providers with respect to whether answering machine messages included the ability to page the physician, non-emergency contact information, the ability to leave a message, information on when a callback could be expected, and the physician's office hours. No statistically significant differences between the two provider groups or between specific Medallion II MCOs were observed. Over 70% of providers in both programs provided information on normal office hours and 67% in each program provided paging information. In contrast, callback information was provided by less than 12% of providers in either program.

Figure B8. Percent of Answering Machines with Specific Features



Discussion

During this study, we compiled extensive information on the 24-hour, 7-day access by phone to health care for the MEDALLION and Medallion II programs. Of 480 calls placed by research interviewers 90% received a valid response and 80% enabled a plan participant to obtain information on what to do in an emergency situation. No statistically significant differences were observed in the ability to obtain after-hours assistance based on the time of day (early am vs. late pm), time of week (weekend vs. weekday), physician specialty (family practice, pediatrics, internal medicine), program affiliation (MEDALLION vs. Medallion II), or plan affiliation (specific Medallion II MCOs compared to each other). Emergency access increased substantially from 2002, when only 70% of phone calls reached a valid contact. Of the valid phone responses, a live person answered one-third, with personnel from an answering service taking a majority of those calls for both the MEDALLION and Medallion II samples. Electronic answering devices answered the remaining two-thirds. These findings indicate that 24-7 phone access coverage is reasonable and has improved from one year ago. However, improvement in this area still can benefit Medicaid recipients in the Commonwealth of Virginia.

This study's sampling approach provides strong grounds for drawing conclusions about phone access to care on weekends and between 7 pm and 7 am on weekdays—periods of time when physician office visits are generally not available and when the only available medical care may be through a hospital emergency room. By randomly assigning each plan's phone calls to one of thirty time blocks, with two early morning and two

late evening time blocks on each of the five work days and the weekends and two afternoon time blocks on the weekends, the design allowed for strong conclusions to be drawn concerning whether time period affected phone access to providers. And by drawing samples of 80 telephone numbers from MEDALLION and each Medallion II MCO, there was moderate power to detect differences between those programs with respect to access to after-hours care.

Because this survey included a large random sample, the conclusions drawn from this study can be generalized to apply to the population of providers in the MEDALLION and Medallion II programs. In many cases, multiple providers share the same phone number, which means that generalizations based on 480 phone numbers can directly assess phone access to a substantially larger number of providers. Moreover, because many of the sampled providers are affiliated with several of the specific Medallion II MCOs and, in some cases, also with the MEDALLION program, results reported for particular plans or programs also provide information on care received by participants in the other plans or programs.

Beyond the conclusions that can be drawn from this year's study, results become more useful to DMAS because they build on last year's study, which was quite comparable to this year's. By comparing major conclusions from last year's and this year's studies, it is possible to examine trends impacting the quality of care available to participants in the MEDALLION and Medallion II programs. Whitmore (1997) and others have noted that policy makers benefit from longitudinal monitoring that allows them to detect trends and examine changes that result as MCOs expand and mature. Such monitoring is essential for quality improvement efforts.

Although this study provides a strong overview of 24-hour, 7-day phone access to providers, it does have several limitations that should be noted. First, in consultation with DMAS, a decision was made to limit phone calls to periods outside those when physician offices are normally open. While this design choice allows for stronger generalizations about phone access to providers in these periods of time, it does not provide information about how easy it is to reach providers during normal business hours. Last year's study found that it was more difficult to reach providers during normal business hours than it was to reach their answering machines or answering services in times the office was closed. Because of this design difference, some comparisons between this year's and last year's studies should be made cautiously, because some may be explained by the fact that more phone calls last year were made during working hours when calls were more likely to be answered by office staff, the phone number was busy, or the caller was placed on hold.

A second limitation to the study design is that it did not consider some variables that also may impact access to care. This limitation was noted in last year's report and additional analyses were performed this year to take into account some additional factors. Specifically, this year's study obtained information on the specific Medallion II MCOs that providers affiliate with and used this information to draw a more representative sample from each MCO. Data on provider's specialty code is also substantially more complete this year. As

a result, this year's report could draw stronger and more accurate conclusions about how specialty may impact phone access to care.

Including additional variables in analyses are a desirable goal, but one that is impacted by the study's third major limitation. Although a sample of 80 telephone numbers from the MEDALLION program and an additional 400 drawn evenly from the five Medallion II plans is substantial, statistical tests that are based on subgroups have very limited statistical power. As a result, although adding variables such as region, practice size, or the number of plans providers affiliate with is desirable, when these explanatory variables are combined with others already included in the design, results are based on sample sizes that make conclusions extremely tentative.

Perhaps the most significant finding in this year's study is the substantial improvement in rates of reaching valid provider phone numbers with appropriate emergency contact information. The number of valid phone numbers for both MEDALLION and Medallion II providers increased from about 70% a year ago to 90% this year. Part of this improvement may reflect higher quality information in the databases from which our sample was drawn. While improved accuracy and currency of the databases does not directly impact care, accurate databases are a vital part of data-driven quality improvement activities. It is also likely that some of the increase in valid contacts may be because this year's study did not include calls during normal working hours, when last year's study found the greatest number of access problems. However, valid calls outside of office hours also increased from a year ago, as did the percent of answering machines that provided needed emergency contact information.

Another major finding in this year's study is that there were negligible differences in the phone access available to participants in the MEDALLION program and in each of the specific Medallion II MCOs. While samples from each plan (80) were small enough so that some differences may not have been detectable (Cohen, 1988), each plan's rates of emergency phone access information was higher than the rates reported for both MEDALLION and Medallion II one year ago. Thus, it appears that all plans are progressing with respect to the phone access to care available to their participants.

Last year's reports identified the value of exploring demand for after-hours medical care and its relationship to quality of care and customer satisfaction. It is important to answer questions such as:

- Who needs access to medical care outside of business hours?
- How frequently do they use it?
- Are patients satisfied with service?
- Do patients know about services available to them?
- Is there equity in access (e.g., what about families without telephones)?
- Is triage performed by medical personnel via telephone effective?

Answering such questions can help the Commonwealth better understand potential cost savings and quality of care improvements that might be effected by further attention to the use of telephone access (e.g., Kempe et al., 2003; Leibowitz, Day, and Dunt, 2003; Lee Guzy, Johnson, Woo, and Baraff, 2002; Gallagher, Huddart, and Henderson, 1998; Kempe, Dempsey et al., 2000; and O'Connell, Stanley, and Malakar, 2001).

Evaluating the demand for, quality of, and satisfaction with health care when 24-hour, 7-day access is provided could help policy makers develop responsive care systems that optimize resource use.

Conclusions and Recommendations

The results of this study suggest that a substantial majority of providers meet the MEDALLION and Medallion II program accessibility requirements and that this percentage has increased substantially. Specifically stated requirements deal with how calls by enrollees should be handled and what information should be given. Table 9 summarizes key quality issues identified with this study along with recommendations for improvement. Because results from MEDALLION and the specific Medallion II plans were not distinguishable, recommendations for all plans are combined.

Table 9. Quality issues and suggestions for improvement in the Virginia Medicaid MEDALLION and Medallion II 24-hour, 7-day per week accessibility to care.

Provider Requirement	Quality Issue	Recommendation
Providers are required to have information about services available 24 hour, 7 days per week via telephone.	• Over 10% of calls made to the sampled telephone numbers in the MEDALLION and Medallion II programs did not reach a medical care or medical information service provider. • When callers were able to reach medical care or medical information service providers, frequently answering services handle the calls.	• Updating provider databases should remain a priority each year. • Regular calls to provider offices after hours by MCO staff would help to identify non-conformity against requirements. • Answering services should receive special training on appropriate response procedures, including referral to triage.
When an enrollee contacts an answering machine an on-call medical professional should be automatically paged to make referrals for non-emergency services or to give information about accessing services or handling medical problems during non-office hours.	• 90% of the answering machines gave emergency contact info. • 70% of answering machines provided office hours and 67% gave information needed to page a provider who could give further information.	• A more detailed review of answering machines that fail to meet program requirements should be performed to better understand why this occurs and how it can be corrected. • Either all answering machines should page medical personnel or complete non-emergency contact information should be provided.

Barriers to 24-hour, 7-day-access may decrease the utilization of physician office services, which in turn may increase use of more expensive medical services and harm the quality of care (Leibowitz et al., 2003; Hildebrandt, Westfall, and Smith, 2003). Potential barriers to 24-7 access to care identified in last year's study have shown substantial improvement this year. Reduced barriers include: 1) out of date provider contact information remains a concern, but has declined substantially; 2) answering services continue to respond to after-hours calls, but such services may provide more reassurance than an answering machine; and 3) some answering machines still provide incomplete information, but this percentage is dropping.

To continue the improvements observed this year, several steps can be taken. These include:

1) Providers with invalid numbers should be contacted. Such contacts may lead to corrected contact information that will directly benefit quality of care. This will also lead to a better understanding of whether incorrect information is caused by, a) databases not reflecting information corrected in sources available to the patient; b) providers who no longer participate in the program; or c) other unknown

causes. Beyond directly improving care, information obtained through contacting providers will allow DMAS to most efficiently use quality monitoring and improvement resources.

2) Next year's study should consider drawing physician contact information directly from the sources available to the patients. Plans have printed booklets that provide physician contact information, websites that provide these phone numbers, or both. If next year's study obtains the phone numbers using the same methods available to plan participants, results will more closely reflect the experiences of the participants.
3) Aggregate results of this study should be provided to MEDALLION and Medallion II providers and representatives from each program. Because issues dealing with answering machines are quite easy to fix, publicizing what a "good" answering machine message should include may produce improvements in patient access to care quickly and efficiently.
4) Analyses of emergency room utilization data may allow DMAS to focus on providers whose after-hours phone access is critically important. Emergency room visits represent a substantial cost to the Medicaid program. While some are clearly necessary, better phone triage and after-hours access to physicians is associated with reduced emergency room visits (Chan, Vilke, Smith, Sparrow, and Dunford, 2003; Hildebrandt et al., 2003). Identifying providers with extremely high or low rates of patients' ER visits that do not lead to an admission can be used to perform a detailed examination of the availability and quality of their after-hours phone access.
5) More information on the number and size of answering services used by physicians is important to obtain. Evidence indicates that call centers can be successfully implemented and can improve patients' quality of care Kempe, Luberti at al (2000) and Rose (1999). However, recent research has shown that advice provided by physicians produces high patient satisfaction and compliance than advice from a nurse consultant (Lee et al, 2002). Kempe (2003) has also shown that nurse triage followed by referral to a physician produced lower urgent care visits than other models. The American Academy of Pediatrics (November, 1998) has noted that standardized quality assurance guidelines for medical call centers are lacking. This report offers preliminary suggestions for issues to be considered in the development of such guidelines. Without understanding the number and size of such centers operating in the Commonwealth, it will be difficult to build consensus around standards that can improve patient care quality and reduce expense.

Beyond demonstrating that a large majority of providers in the MEDALLION and Medallion II programs are meeting 24-7 access requirements, this study points to important opportunities to improve patients' access to care whenever it is needed. And while the focus of this study has not been on patient's experiences in the physician's office, it is important to recognize the relationship between that care and 24-7 phone access. Short wait times for appointments and high quality patient care in the office may reduce the need for emergency care or advice after hours. Conversely, effective 24-7 care may enable providers to better manage patient flow and improve the quality of care patients receive in their offices. While improvements need to continue, this year's study shows promising improvement regarding 24-7 access in the MEDALLION and Medallion II programs.

Appendix C – 2002 Medallion II External Quality Review Executive Summary

Medallion II Overview

Medicaid managed care originated in Virginia in 1991 when the Commonwealth developed a managed care program under a 1915(b) waiver from the Centers for Medicare and Medicaid Services (CMS). This original managed care program, called MEDALLION, was operated as a primary care case management model and was expanded to include the entire state in 1995. In 1996, Medallion II, a full-risk mandatory Medicaid managed care program, was built to supplement the Commonwealth's previous initiatives to expand the use of managed care for the delivery of health care to Medicaid recipients with the intent being to improve access to care, promote disease prevention, ensure quality care, and reduce Medicaid expenditures. Eligible Medicaid recipients enroll in a participating Managed Care Organization (MCO) of their choice and select a Primary Care Physician (PCP) to oversee their medical care. The MCO is responsible for developing and operating a provider network, negotiating fees with providers, and operating a system that provides utilization and quality oversight of the health services delivered to its enrollees.

As of July 1, 2003, the following Medallion II MCOs were providing health care services to nearly 263,000 Commonwealth of Virginia Medicaid recipients:

- Anthem HealthKeepers Plus (formerly Trigon and including three MCO product lines),
- CareNet (operated by Southern Health Services Inc.),
- Sentara Family Care (operated by Optima Health.),
- UNICARE MCO of Virginia (operated by Wellpoint), and,
- Virginia Premier MCO (operated by Virginia Commonwealth University Health Care System).

External Quality Review Purpose and Objectives

A primary goal of Medallion II is to hold MCOs accountable for delivering high-quality care. To this end, the Department of Medical Assistance Services (DMAS) requires the MCOs to participate in a number of quality assurance and improvement activities. In compliance with the Balance Budget Act of 1997 (BBA) and Section 1932(c)(2)(A)(i) of the Social Security Act, DMAS has contracted with Delmarva Foundation for

Medical Care, Inc. (Delmarva) to serve as the external quality review organization (EQRO) for Medallion II. The EQRO is responsible for providing an independent analysis and evaluation of the Medallion II MCO's ability to provide Medicaid enrollees with services that meet BBA and DMAS contractual requirements for quality, access, and timeliness.

During CY2002, four Medallion II MCOs (Anthem, CareNet, Sentara, and Virginia Premier) participated in an external quality review focused on assessment of their CY2001 operational practices. The purpose of the assessment was to provide a thorough and fair evaluation of each MCO's level of compliance with the Commonwealth's Medallion II contractual requirements and standards of practice established in three categories: quality improvement (QI), utilization management (UM) including pharmaceutical management, and grievance system. The goals of the review included:

Increasing MCO awareness of and compliance with contractual requirements:

- Assessing operational and policy compliance with contractual requirements;
- Providing feedback to the Commonwealth regarding MCO contractual compliance for the three selected categories; and
- Providing feedback to MCOs concerning improvement of operational practices, as well as clarification of policies and procedures.

In areas where deficiencies were noted, the MCOs were required to submit corrective action plans and were provided recommendations that if implemented, should improve MCO performance in future reviews. In cases where corrective action plans were required, all were submitted to DMAS and deemed adequate.

As follow-up to the previous year's external quality reviews, the following activities were conducted during the current external quality review:

- A comprehensive off-site desk review of UNICARE (a new Medallion II MCO in CY2002) to assess the MCO's level of compliance with all standards related to quality management, utilization management, and grievance system;
- An off-site desk review of each MCO's (Anthem, CareNet, Sentara, and Virginia Premier) compliance with quality management, utilization management, and grievance standards, including modifications to policies and procedures in response to the prior year's on-site review findings;
- An off-site desk review of two quality studies undertaken by each of the MCOs (Anthem, CareNet, Sentara, and Virginia Premier) during CY2002 and review of modifications to clinical quality studies initiated in CY2001; and,

- An assessment of all five MCOs' (Anthem, CareNet, Sentara, UNICARE, and Virginia Premier) pharmaceutical management practices through review and analysis of each MCO's response to a pharmaceutical survey.

External Quality Review Findings

This section presents an overview of the findings of the Quality Management (QM), Utilization Management (UM), and grievance system reviews for the Medallion II MCOs. Figure C1 provides MCO comparison results for all review components. This comparison represents UNICARE's year one review findings compared to the year two findings, after implementation of corrective action in response to the year one results, of the other MCOs. It is important to note that as a newly participating MCO in CY2002, many review components were "not applicable" to UNICARE as the data and enrollment periods necessary to conduct many activities had not been in place long enough to be representative of the MCO's population and operational performance.

Figure C1. Summary Quality Review Results

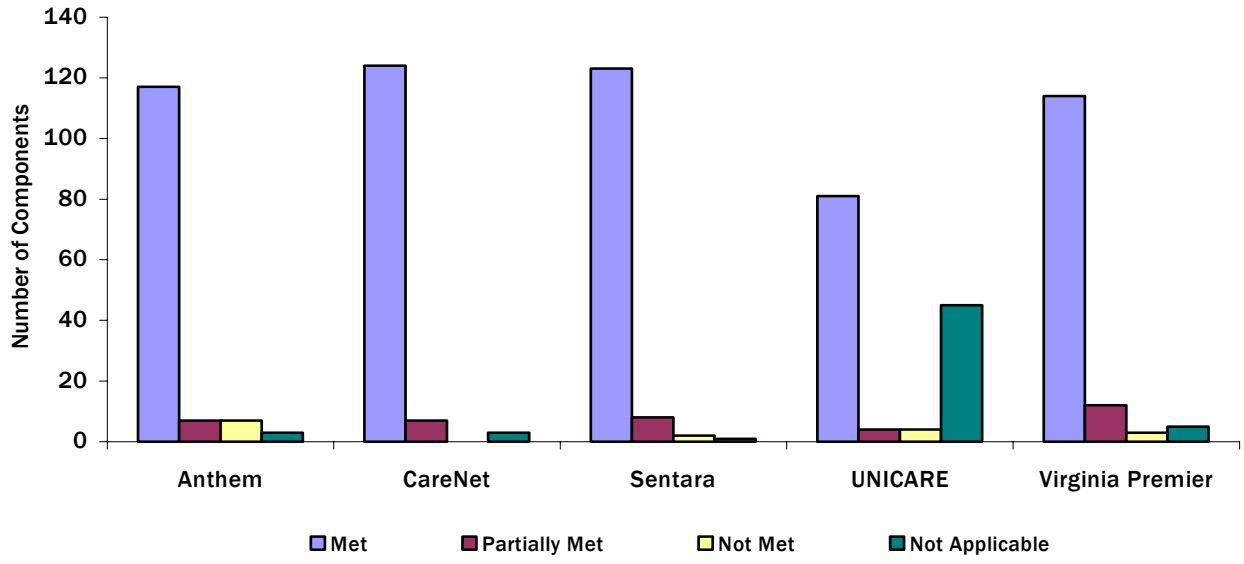


Table C1 provides an overview and comparison of MCOs by component performance for each of the MCO management systems assessed as part of this review.

Table C1. Summary Quality Review Results for each MCO.

	Anthem	CareNet	Sentara	UNICARE	Virginia Premier
Quality Management					
Met	30	29	30	11	20
Partially Met	0	1	0	2	8
Not Met	0	0	0	0	0
Not Applicable	0	0	0	17*	2
Utilization Management					
Met	41	41	35	25	38
Partially Met	2	2	8	2	3
Not Met	0	0	0	0	2
Not Applicable	0	0	0	16*	0
Grievance System					
Met	46	54	58	45	56
Partially Met	5	4	0	0	1
Not Met	7	0	2	4	1
Not Applicable	3	3	1	12*	3
MCO Totals					
Met	117	124	123	81	114
Partially Met	7	7	8	4	12
Not Met	7	0	2	4	3
Not Applicable	3	3	1	45*	5
Total Components	**134**	**134**	**134**	**134**	**134**

* UNICARE had a large number of components scored as "not applicable" for this 2003 quality review. The exempted review components require on-site inspection of MCO operational procedures and systems to complete a comprehensive baseline assessment.

Quality Management Results

As Medicaid has moved into the managed care arena, MCOs have been mandated to build quality and accountability into their health care delivery systems. Quality initiatives have the ability to enhance administrative and clinical practices, increase access to sources of care, promote quality by developing and encouraging use of accepted clinical practice standards, increase use of preventive services, decrease unnecessary hospitalizations, and build organizational capacity to improve managed care services.

The Quality Management program review is an assessment of each MCO's ability to develop a system for on-going monitoring and improvement activities and to encompass components that assess an MCO's ability to develop a comprehensive written quality management program description, develop policies and procedures for implementation of the program, and maintain appropriate documentation to substantiate that the program has been implemented as described. The assessment is accomplished through review of written policies, procedures, and any other reports or documents submitted by the MCOs. Additionally, a review of each MCO's clinical quality improvement studies is undertaken to assess the MCO's ability to appropriately develop study topics, questions, and indicators representative of their populations and to implement interventions that have the potential to result in meaningful improvement.

In general, the plans performed well on components of the review related to Quality Management. However, better documentation of study designs and related interventions were noted to be areas for improvement across MCOs. Table C2 provides a comparison of MCOs across Quality Management components.

Table C2. Quality Management Review Results for each MCO.

Review Elements	Anthem	CareNet	Sentara	UNICARE	Virginia Premier
A. Quality Management					
1. Quality Improvement Program					
A.1.1. Annual QIP submitted to the Commonwealth with all study results.	Met	Met	Met	N/A	Met
A.1.2. HEDIS and other study results gathered as part of final report.	Met	Met	Met	N/A	N/A
A.1.3. HEDIS results benchmarked against appropriate benchmarks.	Met	Met	Met	N/A	N/A
A.1.4. Study results analyzed and documentation of analysis documented in QI committee notes.	Met	Met	Met	N/A	Met
A.1.5. QIP demonstrates plan to have CAHPS completed with results to DMAS by July 2002. CAHPS results gathered for report, if available.	Met	Met	Met	N/A	Met
A.1.6. QIP demonstrates focused QI activities for all outcomes below benchmark/goal/target or rationale why activities are not in place.	Met	Met	Met	N/A	Partially Met
A.1.7. All QI corrective action plans have assigned staff person for responsibility for improvement.	Met	Met	Met	N/A	Met

Review Elements	Anthem	CareNet	Sentara	UNICARE	Virginia Premier
A. Quality Management					
A.1.8. *Each study description demonstrates:*					
A.1.8a. Defined study topic(s).	Met	Met	Met	Met	Met
A.1.8b. Defined study question(s).	Met	Met	Met	Met	Met
A.1.8c. Defined study indicator(s).	Met	Met	Met	Met	Met
A.1.8d. A representative and generalizable study population.	Met	Met	Met	Partially Met	Partially Met
A.1.8e. Sound sampling techniques.	Met	Met	Met	N/A	Partially Met
A.1.8f. Robust data collection methodology.	Met	Met	Met	N/A	Partially Met
A.1.8g. Implementation of interventions and improvement strategies.	Met	Met	Met	N/A	Met
A.1.8h. Interpretation of study results.	Met	Met	Met	N/A	Partially Met
A.1.8i. Plan for real improvement.	Met	Partially Met	Met	N/A	Partially Met
A.1.8j. Focus on sustained improvement.	Met	Met	Met	N/A	Partially Met
2. Quality Studies: Provider Cooperation					
A.2.1.QIP submitted to Commonwealth with all study results.	Met	Met	Met	N/A	Met
A.2.2. Network provider contracts (physicians and hospital) demonstrate cooperation with quality initiatives, including access to records and open practitioner-patient communication.	Met	Met	Met	Met	Met
A.2.3. QI studies and feedback from staff demonstrate that providers generally cooperate with QI study chart abstraction.	Met	Met	Met	N/A	Met
3. Coordination and Continuity of Care					
A.3.1. The contractor has policies and procedures that reflect assurance of the coordination and continuity of care.	Met	Met	Met	Met	Met
A.3.2. The contractor has policies and procedures demonstrating that when a PCP or specialist terminates with the contractor, the contractor notifies members at least 30 days prior to termination and assists them in selecting a different PCP or specialist.	Met	Met	Met	Met	Met
A.3.3. *The contractor has policies and procedures demonstrating that a member can retain assignment to a terminated practitioner, if*					
A.3.3a. The member is undergoing active treatment for a chronic or acute medical condition for the duration of treatment or 30 days, whichever is the lesser; or	Met	Met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UNICARE	Virginia Premier
A. Quality Management					
A.3.3b. The member is in the second or third trimester of pregnancy (in this case the member can continue to see the provider through the postpartum period).	Met	Met	Met	Met	Met
4. Coordination of QI Activity with Other Management Activity					
A.4.1. The QI committee minutes reflect (at least) quarterly discussion of QI projects.	Met	Met	Met	Partially Met	Met
A.4.2. The QI committee minutes reflect assignment of responsibility for corrective action plans.	Met	Met	Met	N/A	Met
A.4.3. QI committee routinely evaluates corrective action plans for effectiveness, and modifications are made if found to be ineffective.	Met	Met	Met	N/A	Partially Met
A.4.4. A system for the monitoring of enrollee grievances is in place.	Met	Met	Met	Met	Met
A.4.5. The above-noted system has categories that offer the chance to identify opportunities for QI, e.g., common grievance of provider type (home health services) and common grievance regarding lack of access to type of services (oncologists).	Met	Met	Met	Met	Met
A.4.6. There are contemporaneous (i.e., created at the time the activity is conducted), dated, and signed minutes that reflect all QI committee decisions and actions.	Met	Met	Met	Met	Met

Utilization Management Results

Utilization Management (UM) provides the MCO with the opportunity to monitor the appropriateness of provider practices so that cost-efficient, as well as quality-enhancing, best practices are followed. In addition, care coordination and support for at-risk enrollees are monitored to ensure that those requiring health care the most are provided services when needed. The UM standard encompasses components that assess an MCO's ability to develop a comprehensive written utilization management program description, develop policies and procedures for implementation of the program, and maintain appropriate documentation to substantiate that the program has been implemented as described. The assessment is accomplished through review of written policies, procedures, and any other reports or documents submitted by the MCOs.

In general, the MCOs performed well when it came to having processes in place to monitor utilization. However, areas for improvement include:

- Revisions to policies and procedures to accurately reflect DMAS requirements for waiving pre-authorization under certain circumstances.

- Better documentation of utilization review activities including criteria application, peer review procedures, communication of outcomes and timeframes for decision-making and notification processes.

Table C3 provides MCO comparisons for each component of the Utilization Management standard.

Table C3. Utilization Management Review Results for each MCO.

Review Elements	Anthem	CareNet	Sentara	UNICARE	Virginia Premier
B. Utilization Management (UM).					
1. UM Program Description					
B.1.1. *UM program description/plan has:*					
B.1.1a. Criteria to evaluate medical necessity.	Met	Met	Met	Met	Met
B.1.1b. Information source for obtaining medical information.	Met	Met	Met	Met	Met
B.1.1c. The process used to review and approve the provision of medical services, including the evaluation of medical necessity.	Met	Met	Met	Met	Met
B.1.1d. Been reviewed annually by senior staff or the QI committee.	Met	Met	Met	Met	Met
B.1.2. Policies reflect that coverage decisions that depend upon prior authorization (PA) and/or concurrent review to determine medical necessity must be supervised by qualified medical professionals and completed within 2 days PA or 1 day (concurrent review) after receipt of all necessary information.	Met	Met	Met	Partially Met	Met
B.1.3. A designated senior staff physician is available at all times for utilization review. Policies and procedures, staff interviews, and on-site review of UR documentation reflect that all medical denials are made upon physician-level review.	Met	Met	Met	Met	Met
B.1.4. New UM staff members have training and mentoring for appropriate application of UM criteria.	Met	Met	Met	Met	Met
B.1.5. New staff members are evaluated for proper application of UM criteria.	Met	Met	Met	Met	Met
B.1.6. All staff members are evaluated annually for proper application of UM criteria or more often as applicable.	Met	Met	Met	Met	Met
B.1.7. The UM program demonstrates mechanisms to detect underutilization and/or over utilization of care, including, but not limited to, provider profiles.	Met	Met	Met	Met	Met
B.1.7a. Reports generated regarding over- and underutilization are evaluated at least annually and documentation of this evaluation is in UM and/or QI committee minutes.	Met	Met	Met	Met	Not Met

Review Elements	Anthem	CareNet	Sentara	UNICARE	Virginia Premier
B. Utilization Management (UM).					
B.1.7b. Trends or abnormal reports regarding over- and underutilization have appropriately assigned staff and corrective action plan with monitoring of corrective action plan.	Met	Met	Met	Met	Not Met
B.1.8. The UM plan has been submitted to the Commonwealth annually and upon revision.	Met	Met	Met	N/A	Met
B.1.9. Current UM policies and procedures reflect that preauthorization does not apply to emergency care, family planning services, preventive services, and basic prenatal care.	Met	Met	Partially Met	Partially Met	Met
2. Utilization Review Case Documentation					
B.2.1*. Case reviews reflect:*					
B.2.1a. Evaluation and documentation of medical necessity based on review criteria.	Partially Met	Met	Partially Met	N/A	Partially Met
B.2.1b. Evaluation and documentation by appropriately licensed staff.	Met	Partially Met	Partially Met	N/A	Partially Met
B.2.1c. Review completed and decision communicated to provider and member within 1 day of receipt of medical information.	Partially Met	Partially Met	Partially Met	N/A	Met
B.2.2. Physician review for all medical denials.	Met	Met	Met	N/A	Met
3. Utilization Management Program Policies and Procedures					
B.3.1. For pre-certifications of non-urgent care, the MCO makes decisions within 2 working days of obtaining all the necessary information.	Met	Met	Met	Met	Met
B.3.2. For pre-certifications of non-urgent care, the MCO notifies practitioners of the decisions within 1 working day of making the decision.	Met	Met	Partially Met	Met	Met
B.3.3. For pre-certifications of non-urgent care that result in a denial, the MCO gives members and practitioners written or electronic confirmation of the decisions within 2 working days of making the decision.	Met	Met	Met	Met	Met
B.3.4. For pre-certifications of urgent care, the MCO makes decisions and notifies practitioners of the decisions within 1 calendar day.	Met	Met	Partially Met	Met	Met
B.3.5. For pre-certifications of urgent care that result in a denial, the MCO notifies both members and practitioners of how to initiate an expedited appeal when they are issued the denial notification.	Met	Met	Met	N/A	Met
B.3.6. For pre-certifications of urgent care that result in a denial, the MCO gives members and practitioners written or electronic confirmation of the decisions within 2 working days of making the decision.	Met	Met	Met	Met	Met
B.3.7. For concurrent review, the MCO makes decisions within 1 working day of obtaining all the necessary information.	Met	Met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UNICARE	Virginia Premier
B. Utilization Management (UM).					
B.3.8. For concurrent review, the MCO notifies practitioners of decisions within 1 working day of making the decision.	Met	Met	Partially Met	Met	Met
B.3.9. For concurrent review decisions that result in a denial, the MCO gives members and practitioners written or electronic confirmation within 1 working day of the original notification.	Met	Met	Partially Met	Met	Met
B.3.10. For concurrent review decisions that result in a denial, the MCO notifies both members and practitioners of how to initiate an expedited appeal when they are issued the denial notification.	Met	Met	Met	Met	Met
B.3.11. For retrospective review, the MCO makes the decision within 30 working days of obtaining all the necessary information.	Met	Met	Met	Met	Met
B.3.12. For retrospective review, the MCO notifies practitioners and members of denials in writing within 5 working days of making the decision.	Met	Met	Met	Met	Partially Met
B.3.13. The MCO makes the expedited appeal decision and notifies the member or practitioner(s) as expeditiously as the medical condition requires, but no later than 72 hours after the review commences.	Met	Met	Met	Met	Met
B.3.14. The MCO provides written confirmation of its decision within 2 working days of providing notification of the decision, if the initial decision was not in writing.	Met	Met	Met	N/A	Met
B.3.15. The MCO covers emergency services necessary to screen and stabilize members without pre-certifications in cases in which a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.	Met	Met	Met	Met	Met
B.3.16. The MCO covers emergency services if an authorized representative acting for the MCO has authorized the provision of emergency services.	Met	Met	Met	Met	Met
B.3.17. The MCO monitors utilization data across practices and provider sites for PCPs and high-volume specialists to detect potential under- or over utilization.	Met	Met	Met	N/A	Met

Grievance System Results

The grievance system provides an opportunity for an enrollee whose request for health services is reduced, denied or not acted upon promptly to request an appeal of the MCO's decision. Because the Medicaid

population is a unique group, it is deemed important to review the notification processes and documents for consistency in messages being delivered to the members and to provide appropriate tracking mechanisms to ensure communication is being delivered in a timely manner. In assessing the MCO's ability to provide an effective system for managing grievances, the MCO's written policies and procedures, denial case review, the MCO's grievances and appeals tracking system, policies specifically related to notifying DMAS of appeals, and monitoring and evaluation of enrollee grievance were reviewed.

In general, the review found that MCOs should focus improvement activities on how to adequately describe the appeals process for enrollees and development of policies and procedures for notification and tracking of cases through the appeals process. Corrective action in this area would likely make the largest impact on overall MCO compliance.

The overall findings in regards to the MCOs' Grievance Systems are provided in Table C4.

Table C4. Grievance System Review Results for each MCO.

Review Elements	Anthem	CareNet	Sentara	UNICARE	Virginia Premier
C. Grievance System					
1. Contractor Policies and Procedures for Grievances					
C.1.1. Policies, procedures, and written enrollee materials describe:					
C.1.1a. An informal grievance process.	N/A	N/A	Met	Met	N/A
C.1.1b. A formal grievance process that identifies:	Met	Met	Met	Met	Partially Met
C.1.1b.i. Timely resolution.	Met	Met	Met	Met	Met
C.1.1b.ii. A staff member responsible for processing the receipt, tracking, reviewing, and reporting of enrollee grievances.	Met	Met	Met	Met	Met
C.1.1.b.iii. A grievance log that is maintained and summarizes each grievance, dates of receipt, decision, and the nature of the decision and distinguishes between Medicaid and commercial clients.	Met	Met	Met	Met	Met
C.1.2. A written request for grievance and appeal shall be filed within 30 days of the enrollee's receipt of the notice of an adverse action.	Not Met	Met	Met	Met	Met
C.1.3. Disputes concerning any aspect of service delivery are resolved through verbal informal or written formal grievance process operated by MCO or through DMAS appeals process. A provider may act on an enrollee's behalf.	Met	Met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UNICARE	Virginia Premier
C. Grievance System					
C.1.4. Any written communication from an enrollee or enrollee's provider that clearly expresses the request to present the case to a reviewing authority constitutes an appeal request.	Met	Met	Met	Met	Met
C.1.5. Pending resolution of a written grievance, coverage shall not be terminated for the enrollee for any reason that is the subject of the written complaint.	Met	Met	Met	Not Met	Met
C.1.6. The difference between informal and formal grievance is defined, and processes are described identifying the difference.	N/A	N/A	Met	Met	N/A
C.1.7. The policies and procedures identify a tracking mechanism for formal and informal grievances.	Met	Met	Met	Met	Met
C.1.8. For the first-level appeal, the MCO appoints a review panel composed of representatives who were not involved in the initial determination.	Met	Met	Met	Met	Met
C.1.8a. The person or persons appointed to review an appeal involving clinical issues include(s) at least one practitioner in the same or similar specialty that typically manages the medical condition, procedure, or treatment.	Met	Met	Met	Met	Met
C.1.9. For the second-level appeal, the MCO appoints a panel composed of representatives who were not involved in the first-level appeal.	Met	Met	Met	Met	Met
C.1.9a. The panel appointed to review an appeal involving clinical issues include(s) at least one practitioner in the same or similar specialty that typically manages the medical condition, procedure, or treatment.	Met	Met	Met	Not Met	Met
C.1.9a.i. The member has a right to appear before the panel.	Met	Met	Met	Met	Met
C.1.9a.ii. The MCO offers a second-level review to happen within 45 days of receiving the request.	Met	Met	Met	Not Met	Not Met
C.1.9a.iii. A member who is unable to appear in person at the panel hearing is provided the opportunity to communicate with the panel by conference call or other appropriate technology.	Met	Met	Met	Met	Met
C.1.9a.iv. When an appeal is for an acute or urgent condition, the MCO follows the expedited appeals procedure.	Met	Met	Met	Met	Met
C.1.10. The above-noted tracking system is linked to appropriate QI processes.	Met	Met	Met	Met	Met
C.1.11. The MCO designates an internal review board to create and review confidentiality policies and to review practices regarding the collection, use, and disclosure of medical information.	Met	Met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UNICARE	Virginia Premier
C. Grievance System					
2. Case Review of Grievances					
C.2.1. *Review all grievances resulting in an appeal and review for the following:*					
C.2.1a. MCO notifies the enrollee in writing that medical necessity, specialist referral, or other service delivery issues may be resolved through the informal and/or formal grievance process.	Met	Met	Met	Met	Met
C.2.1b. MCO notifies the enrollee in writing that the enrollee has the right to appeal directly to DMAS.	Met	Met	Met	Met	Met
C.2.1c. Within 2 business days, MCO provides grievance forms and written procedures to enrollees wanting to register written grievances.	Partially Met	Met	Met	Met	Met
C.2.1d. Within 2 days of receipt of any written request for a grievance, MCO provides DMAS with a copy of the request. MCO issues informal grievance decisions within 7 days from the date of initial receipt of grievance. (Informal decision not required to be written.)	Met	Met	Met	N/A	Met
C.2.1e. MCO issues formal grievance decision in writing within 14 days from the date of initial receipt of the formal grievance and includes:	Met	Met	Met	Met	Met
C.2.1e.i. Decision reached.	Met	Met	Met	Met	Met
C.2.1e.ii. Reasons for the decision.	Met	Met	Met	Met	Met
C.2.1e.iii. Policies or procedures that provide the basis for the decision.	Met	Met	Met	Met	Met
C.2.1e.iv. A clear explanation of further appeal right.	Met	Met	Met	Met	Met
C.2.1f. MCO provides DMAS with a copy of the formal grievance decision concurrently with the provision of decision to the enrollee.	Met	Met	Met	N/A	Met
C.2.1g. An expedited decision shall be issued within 48 hours in case of medical emergencies. Written confirmation of the decision shall promptly follow the verbal notice.	N/A	N/A	N/A	Met	N/A
C.2.1h. Any grievance decision may be appealed to DMAS by the enrollee.	Met	Met	Met	Met	Met
C.2.1i. *Review grievance log for:*					
C.2.1i.i Summary of each grievance.	Met	Met	Met	N/A	Met

Review Elements	Anthem	CareNet	Sentara	UNICARE	Virginia Premier
C. Grievance System					
C.2.1i.ii. Date of receipt.	Met	Met	Met	N/A	Met
C.2.1i.ii. Decision.	Met	Met	Met	N/A	Met
C.2.1i.iii. Nature of decision.	Met	Met	Met	N/A	Met
C.2.1j. *Review DMAS notification for:*					
C.2.1j.i. Notification within 2 days of receipt of written grievance.	Met	Met	Met	N/A	Met
C.2.1j.ii. Formal grievance notification sent concurrently to DMAS and enrollee.	Met	Met	Met	N/A	Met
C.2.1j.iii. Verification of receipt of information.	Met	Met	Met	N/A	Met
3. MCO Complaint, Grievance, and Appeals Tracking System					
C.3.1. *MCO provides a complaint, grievance, and appeals tracking system that includes:*					
C.3.1a. Original written complaint, grievance, or appeal.	Met	Met	Met	Met	Met
C.3.2. *MCO provides a grievance log that includes:*					
C.3.2.a. Summary of each grievance.	Met	Met	Met	Met	Met
C.3.2.b. Date of receipt.	Met	Met	Met	Met	Met
C.3.2.c. Decision.	Met	Met	Met	Met	Met
C.3.2.d. Nature of the decision.	Met	Met	Met	Met	Met
C.3.2.e. Log shall distinguish between Medicaid and commercial clients (unless the MCO maintains a separate system for Medicaid clients).	Met	Met	Met	Met	Met
4. Enrollee Appeals to the Department Policy and Procedure Review					
C.4 *Specify that when a member is notified of an adverse action, the written correspondence includes:*					
C.4.1. The information that the appeal must be filed within 30 days of enrollee receipt of notice to deny, delay, terminate, reduce, or deny payment.	Not Met	Met	Met	Met	Met
C.4.2. The action the MCO intends to take.	Partially Met	Partially Met	Met	Met	Met
C.4.3. The reasons for the intended action.	Met	Partially Met	Met	Met	Met
C.4.4. The specific regulations that support the action or the change in law that requires the action.	Met	Partially Met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UNICARE	Virginia Premier
C. Grievance System					
C.4.5. An explanation of the right to request an evidentiary hearing and the methods and time limits for doing so.	Partially Met	Partially Met	Met	Met	Met
C.4.6. An explanation of the circumstances under which benefits are continued if a hearing is requested.	Not Met	Met	Met	Not Met	Met
C.4.7. An explanation of the right to representation.	Not Met	Met	Met	Met	Met
C.4.8. Process for fair hearing.	Not Met	Met	Met	Met	Met
C.4.9. Explanation of how the enrollee files a grievance/appeal and that the enrollee may appeal directly to DMAS instead of filing with the MCO.	Partially Met	Met	Met	Met	Met
C.4.10. Formulation of an appeal summary submitted within 10 days prior to the hearing.	Not Met	Met	Met	Met	Met
5. Enrollee Appeals to the Department Document Review					
C.5.1. Review MCO tracking for time frame of notification to DMAS.	Not Met	Met	Not Met	N/A	Met
C.5.2. Verify DMAS receipt of information.	Met	Met	Not Met	N/A	Not Met
C.5.3. Review 10 enrollee notifications that include all above elements.	Partially Met	Met	Met	N/A	Met
6. Monitoring and Evaluation of Enrollee Grievance Document Review					
C.6.1. *Review grievance reports for:*					
C.6.1a. Coordination of care/continuity of care.	Met	Met	Met	Met	Met
C.6.1b. The enrollee complaint monitoring system has categories that offer the chance to identify opportunities for QI, e.g., common grievance of provider type (home health services) and common grievance regarding lack of access to type of services (oncologists).	Met	Met	Met	Met	Met

Pharmaceutical Management Review Results

The intent of the pharmaceutical management review was to evaluate the quality of particular components of the pharmacy program within each MCO compared to industry standards.

A questionnaire focusing on three key areas — formulary management, Pharmacy and Therapeutics (P&T) Committee structure and function, and clinical programs and services — was utilized. An evaluation of these areas provides valuable insight into the overall pharmacy program quality.

In general, the assessment demonstrated that the contracted MCOs have established appropriate formulary management procedures, P&T Committee functions, and clinical programs based on quality-focused, industry standards. Highlights of the assessment are outlined below.

- Each contracted MCO supports a closed formulary which is standard within the industry for Medicaid;
- Each MCO has a procedure for assessing medical necessity and providing adequate access to non-formulary medications;
- Anthem, UNICARE, and Virginia Premier support an adequate communication and/or grandfathering strategy for changing formularies;
- Anthem, Sentara, and Virginia Premier support in-house P&T Committees;
- P&T Committees from all MCOs meet at least quarterly; and
- Sentara, UNICARE, and Virginia Premier have met industry standards, including a clinician trained in behavioral health on the P&T Committee.

The following best practice has been identified:

- Anthem's on-line point-of-service pharmacy messaging system offers the pharmacist formulary alternatives. This system provides more convenience for the pharmacist and may result in decreased turn-around times and improved quality of care for the enrollee.

The following opportunities for improvement have been identified:

- UNICARE and CareNet may wish to discuss with other MCOs the benefits of implementing automated standard step therapy programs to improve programs.

The following recommendations for follow-up to the pharmaceutical management evaluation include:

- All MCOs identified pharmacy or provider lock-in programs and some type of inter-departmental coordination when members were identified as inappropriately using medications. A more in-depth examination of how MCOs are identifying inappropriate medication utilization and providing care coordination should be undertaken at the next on-site MCO review;
- Further assessment of policies and procedures for timely identification and implementation of breakthrough therapies, both of new drugs and new uses for old drugs; and,
- Further evaluation of the composition of the P&T Committee structure for Anthem, CareNet, and UNICARE for adequate provider representation.

Conclusions and Recommendations

The review of MCO systems for quality, utilization, and grievance management, while looking at structure process and access of MCO operations, is a process which assures that the Medallion II structure is in fact stable and functioning well enough to result in outcomes of quality. The reviews that have been completed in the past two years in fact bear out that the structure of the Medallion II system performs well in relation to the standards reviewed. In the aggregate, nearly all components were met or at least partially met during the current review with the exception of one MCO. Although UNICARE does not appear to have performed as well as others, it must be taken into consideration that this plan was new to the Medallion II program and many components of the review could not be thoroughly assessed through off-site review activities. To provide for a fair and comprehensive evaluation of the structure and operations of this MCO it is recommended that an on-site quality review be undertaken during the next year. It is anticipated that in CY2003 a trend toward improvement in all MCOs, as well as this specific MCO, will be established and thus the Medallion II aggregate scores would improve in the next review cycle.

All MCOs performed well on the pharmaceutical management review. Each had Pharmaceutical Management procedures in place to ensure adequate access to necessary medications for all enrollees and mechanisms are in place to provide for appropriate formulary review and preferred drug list (PDL) updates. Additionally, methodologies are in place to ensure access to non-formulary pharmaceuticals when appropriate.

Conclusions and recommendations for individual MCOs are as follows:

Anthem

The MCO has fully met the Quality Management standards and has adequately documented on-going quality improvement studies. In the area of Utilization Management, Anthem did not submit cases for review. The

components not reviewed are reflective of timeliness of review determinations and documentation of appropriate application of medical necessity criteria. Both of these areas should be assessed through an on-site review of a randomly selected sample of cases during the next on-site quality review.

Based on the review of documentation submitted by Anthem for the external quality review of the MCO's implementation of corrective actions to address deficiencies identified in the CY 2002 on-site quality review, Anthem does not have many of the appropriate policies and procedures in place for conducting activities related to grievances and appeals processes in accordance with the Balanced Budget Act (BBA) managed care regulations and the Medallion II contract requirements. Anthem must take steps to bring these policies, procedures, and processes into compliance. Written policies and procedures must be reviewed and revised as appropriate to meet regulatory standards.

CareNet

A review of documentation submitted by CareNet for the external quality review of the MCO's implementation of corrective actions to address deficiencies identified in the CY 2002 on-site quality review, found that CareNet has made substantial strides in correcting previously identified areas of deficiency and in bringing policies and procedures into compliance with contractual requirements.

CareNet met all but one component of the Quality Management standard and has adequately documented on-going quality improvement studies. In the area of Utilization Management, CareNet did not submit actual cases for review. The components not reviewed are reflective of timeliness of review determinations and evaluation and documentation by appropriately licensed staff. Both of these areas should be assessed through an on-site review of a randomly selected sample of cases during the next on-site quality review.
In the area of grievance system management, it is recommended that CareNet review the required contents of the notification of denial letters to recipients and providers. It is suggested that the required contents be carefully listed in their policies. Although, most requirements have been added to either the policies or the letters themselves, there needs to be a cohesive system that clearly and consistently identifies the contractual and regulatory requirements.

Sentara

Sentara has fully met the Quality Management standards and has adequately documented on-going quality improvement studies. In the area of Utilization Management, Sentara did not submit documentation to prove that it has appropriately addressed the concerns identified during the CY2002 quality review. The components that could not be assessed are reflective of timeliness of review determinations and documentation of appropriate application of medical necessity criteria. Both of these areas should be assessed through an on-site review of a randomly selected sample of cases during the next on-site quality review.
Based on the review of documentation submitted by Sentara for the external quality review of the MCO's implementation of corrective actions to address deficiencies identified in the CY2002 on-site quality review,

Sentara has developed most of the appropriate policies and procedures for conducting activities related to grievances and appeals processes. However, it is recommended that Sentara develop written policies related to tracking timeliness of notification of appeals and dissemination of appeals summaries to DMAS. Written policies and procedures must be reviewed and revised as appropriate to meet regulatory standards.

UNICARE

Based on the review of documentation submitted by UNICARE for the external quality review of the MCO's systems for Quality Management, Utilization Management, and Grievances, UNICARE has many of the appropriate policies and procedures in place for conducting these activities in accordance with the Medallion II contract requirements. UNICARE must submit a corrective action plan detailing the steps it will take to bring these policies, procedures, and processes into compliance. Written policies and procedures must be reviewed and revised as appropriate to meet regulatory standards. It is also recommended that an in-depth on-site review of UNICARE's operational activities be conducted to assess whether the systems are in place.

Reviewing and addressing the following areas will assist UNICARE in becoming fully compliant with regulatory requirements:

Quality Management

- Modification of the QI Program Description and/or work plan to include:
  - A section documenting the required reporting responsibilities to DMAS
  - Addition of Diabetes as a chosen area of clinical study
  - Include in future QI Minutes more information on why topics for clinical studies were chosen and make sure that any studies chosen receive Committee approval with at least quarterly updates
- Modify study protocols to include:
  - An activity name that succinctly encompasses the purpose of the activity – NCQA recommends beginning with an action word (e.g. decreasing, improving, increasing)
  - A more descriptive rationale area using data from the MCO and information from the literature to substantiate the relevance, priority given to, and the improvability of the study topic
  - Specific descriptions and presentations of study measures, numerators, and denominators to clearly identify exactly what is being measured and what data will be utilized to calculate numerators and denominators
  - Include an over-sampling percentage in the sampling methodology when conducting studies using population samples
  - Describe inclusion and exclusion criteria in sampling methodology
  - Clear benchmarking information – are Medicaid, Commercial, or combined HEDIS benchmarks being used? Are they regional or national rates? If not using HEDIS for benchmarking, what will be used and why?

- Modify Provider Termination policies to include specific Commonwealth contractual requirements including definition of terms and enrollee rights and remove policy statements that are incongruent
- Modify the Provider Model Contracts in the Records Maintenance, Availability, Inspection and Audit section (8.1) to include the words "Quality Improvement activities" after the words Utilization Review
- Synthesize and combine like QI policies to avoid duplication and disagreement of content

Utilization Management

- Review and modify UM prior authorization and concurrent review policies to conform with decision and notification timelines as required in the Medallion II contract
- Establish a system to report results and any corrective actions for inter-rater reliability testing for both nurses and physicians quarterly to the UM Committee
- Revise preauthorization policies to reflect that they do not apply to family planning, preventive, or basic prenatal care/services
- Develop a UM policy regarding required staff orientation and training; submit any UM staff orientation and training programs to the UM committee for approval; provide a staff education quarterly report to the committee

Grievance System

- Prior to the next review, modify all grievance system policies to include BBA updated definition of terms and processes and Medallion II contract requirements including a distinction between formal and informal grievance process, decision and notification timelines, health care benefits coverage continuation, enrollee rights, and MCO reporting responsibilities

Virginia Premier

A review of documentation submitted by Virginia Premier for the external quality review of the MCO's implementation of corrective actions to address deficiencies identified in the previous year's quality review, found that Virginia Premier has made substantial strides in bringing policies and procedures into compliance with contractual requirements. However, corrective action is still required in the following areas:

Quality Management

- Design clinical study reports that provide more detail regarding data, action plans, and evaluations over the course of the studies.
- Identify benchmarks and goals for the clinical studies.
- Identify appropriate improvement activities to be undertaken because of the study outcomes along with an evaluation of the effectiveness of interventions.
- Reflect discussions of study findings in QI and management committee meeting minutes.

Utilization Management

- Tracking over and under-utilization patterns to identify areas for corrective action with documentation in the Medical Management Committee meeting minutes at least quarterly.
- Review the Medallion II contract to ensure that appropriate language is inserted into preauthorization, concurrent, and retrospective review policies.

Grievance System

- Revise the grievance policy to include a statement that the MCO notifies the enrollee of a fair hearing option and that they have 30 days to request this option.
- Incorporate the ten-day requirement for providing DMAS with grievance summary information into the policy. Also, include in the policy a methodology for tracking receipt of the information by DMAS.

It is further recommended that all Medallion II MCOs review the External Quality Review (EQR) protocols established by the Center for Medicare and Medicaid Services (CMS) for assessing Medicaid managed care plans, as this will benefit them in preparing for future reviews. This proactive approach will help to ensure that written policies and operational procedures are compliant with both the Balanced Budget Act (BBA) managed care regulations and Medallion II contractual requirements.

Appendix D – 2002 CAHPS

Members were asked to give their overall ratings of their personal doctor, specialists, health care and health plan. The charts on the following pages show the results for these survey questions.

MEDALLION Adult

Personal Doctor/Nurse

MEDALLION adult members in 2003 gave their personal doctor or nurse an average rating of 8.4 (down from 8.8 in 2001), with 58% specifically giving a very positive rating of 9 or 10. In addition, about 3 in 10 (28%) rated their personal doctor or nurse as a 7 or 8. On the other hand, about one in seven (15%) gave their personal doctor or nurse a rating of 0 to 6.

Specialist

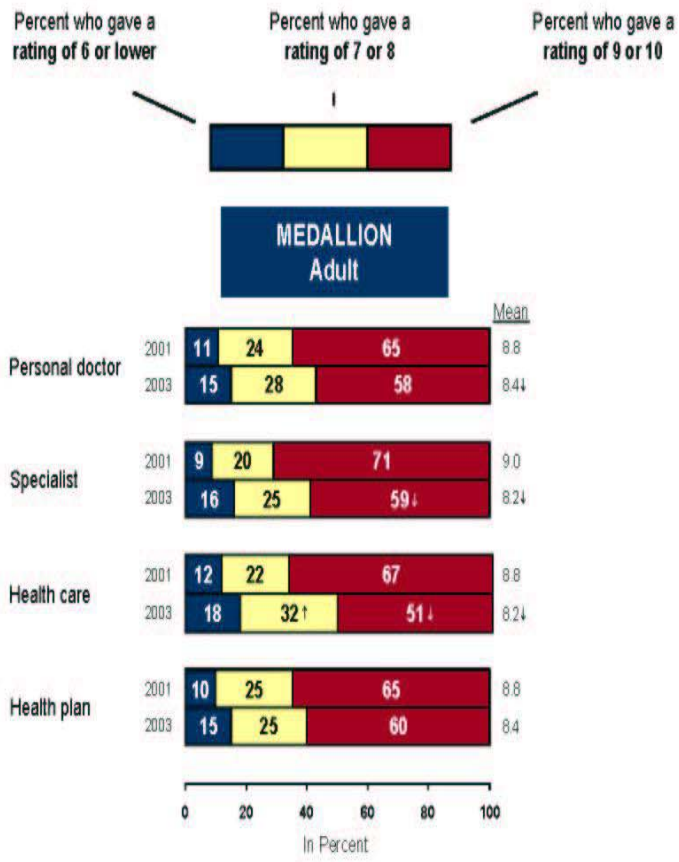
In 2003, MEDALLION adult members gave their specialist an average rating of 8.2 (down from 9.0 in 2001), with 59% (down from 71% in 2001) specifically giving a very positive rating of 9 or 10. In addition, one-fourth (25%) rated their specialist as a 7 or 8. On the other hand, about one in six (16%) gave their specialist a rating of 0 to 6.

Health Care

MEDALLION adult members in 2003 gave their health care overall an average rating of 8.2 (down from 8.8 in 2001), with about one-half of the adult members (51%, down from 67% in 2001) rating their health care overall very positively (rating 9 or 10) and nearly one-third (32%, up from 22% in 2001) giving a rating of 7 or 8. Conversely, roughly two in ten (18%) gave a negative rating of 0 to 6 for their health care overall.

Health Plan

MEDALLION adult members in 2003 gave their health plan an average rating of 8.4, with six in ten (60%) rating their health plan very positively (rating 9 or 10), and one-fourth (25%) rating their health plan as a 7 or 8. On the other hand, about one in seven (15%) gave their health plan negative ratings (rating 0 to 6).



Members were asked to rate the following on a scale of "0 to 10," where a "0" means worst possible and a "10" means best possible:

- Their personal doctor or nurse (AQ5)
- The specialist they see most often (AQ11)
- The health care they've received in the past 6 months (AQ33)
- Their health insurance plan (AQ42)

Base=Those able to rate based on experience

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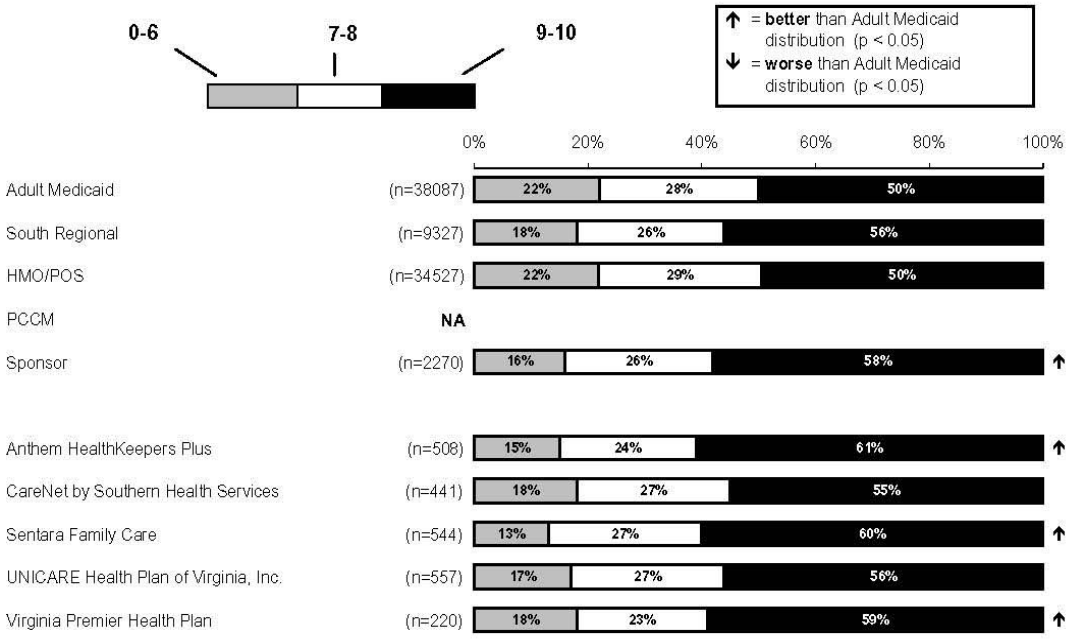
VA Dept. of Medical Assistance Services

Overall Rating of Health Plan

Q52. Using any number from 0 to 10, where 0 is the worst health plan possible, and 10 is the best health plan possible, what number would you use to rate your health plan?



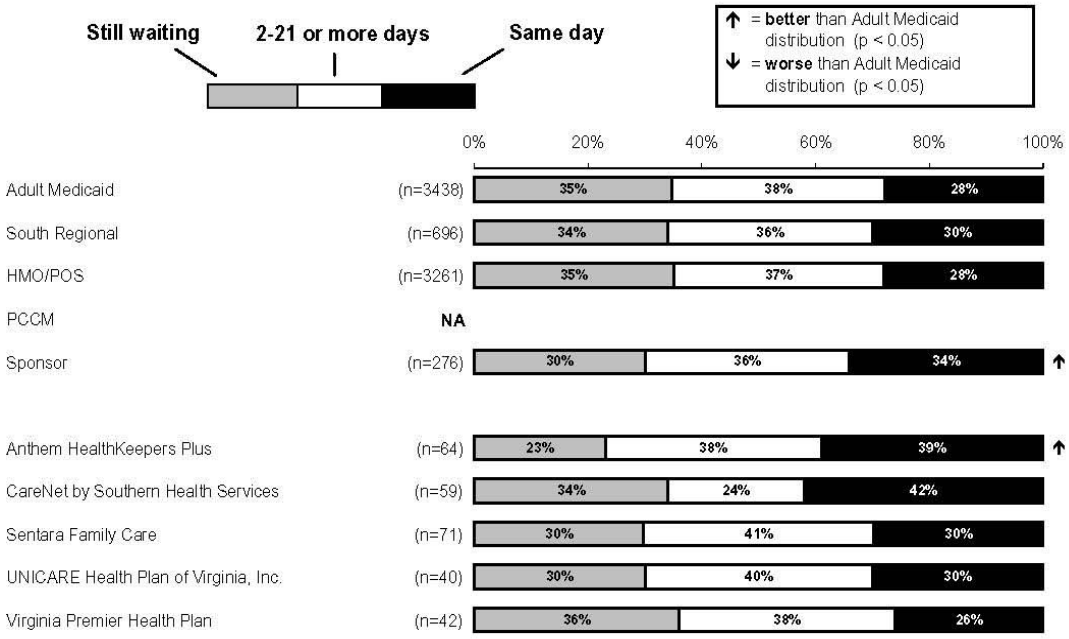
NOTE: The results shown above are case mix adjusted. Small percentage differences may represent measurement (sampling) error rather than actual differences in health plan performance. Response distributions may not sum to 100 percent due to rounding. See the methodology section for more information about the scoring and case-mix methodology.

NCBD 2003 Adult Medicaid Sponsor Report B-32

VA Dept. of Medical Assistance Services

HEDIS Survey Item

Q47. Of those respondents who called or wrote their health plan with a complaint or problem: "How long did it take for the health plan to resolve your complaint?"



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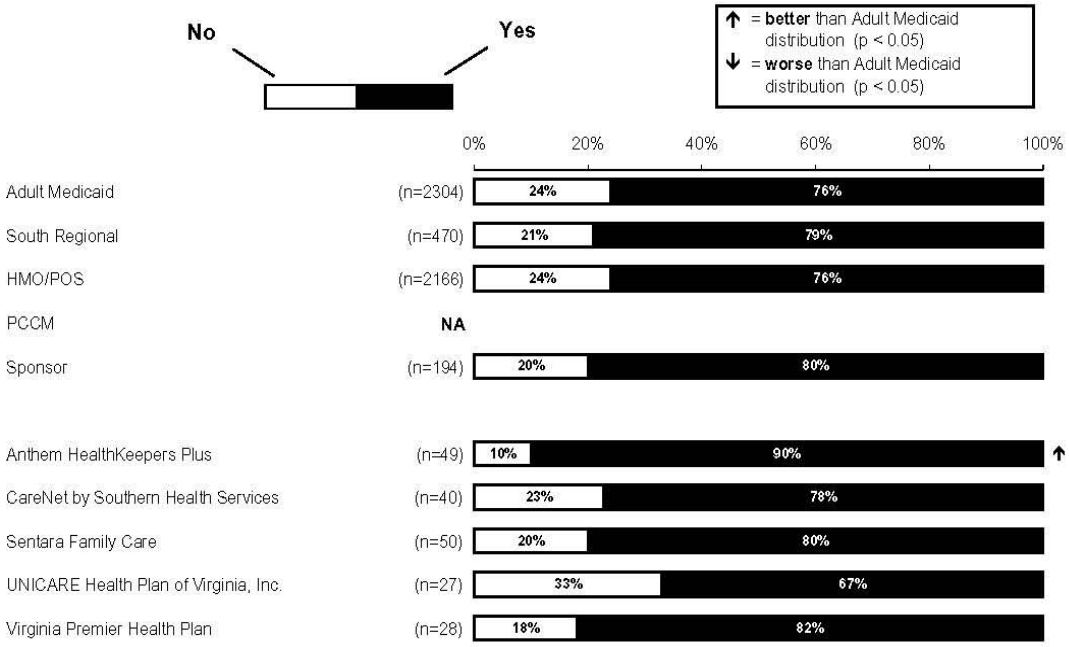
NCBD 2003 Adult Medicaid Sponsor Report B-33

VA Dept. of Medical Assistance Services

HEDIS Survey Item

Q48. Of those respondents whose complaint or problem was resolved: "Was your complaint or problem settled to your satisfaction?"



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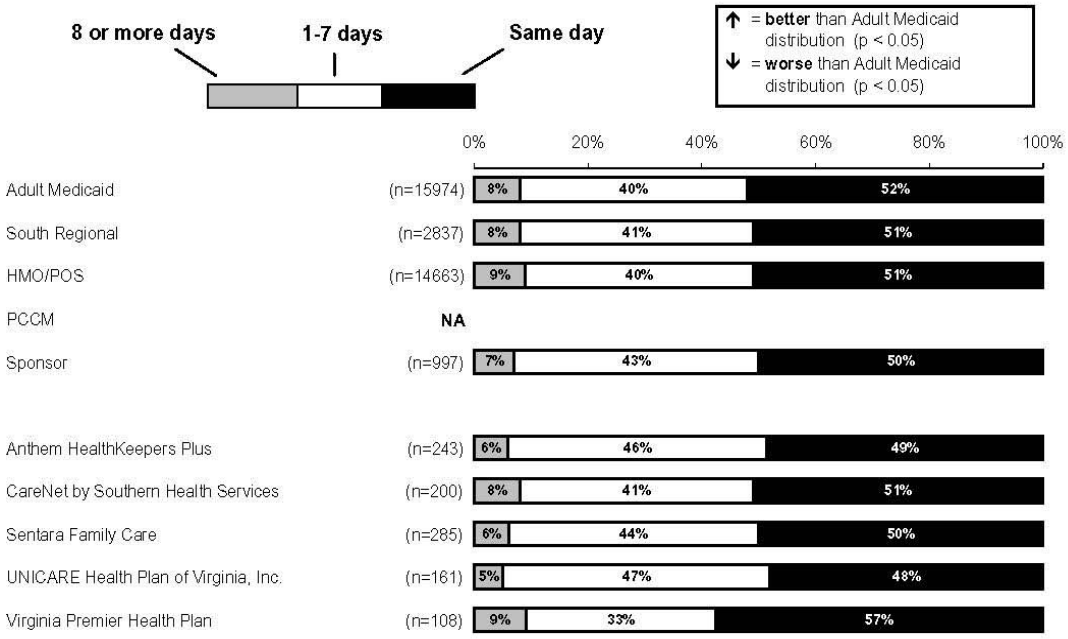
NCBD 2003 Adult Medicaid Sponsor Report B-34

VA Dept. of Medical Assistance Services

HEDIS Survey Item

Q17. In the last 6 months, when you needed care right away for an illness, injury, or condition, how long did you usually have to wait between trying to get care and actually seeing a provider?



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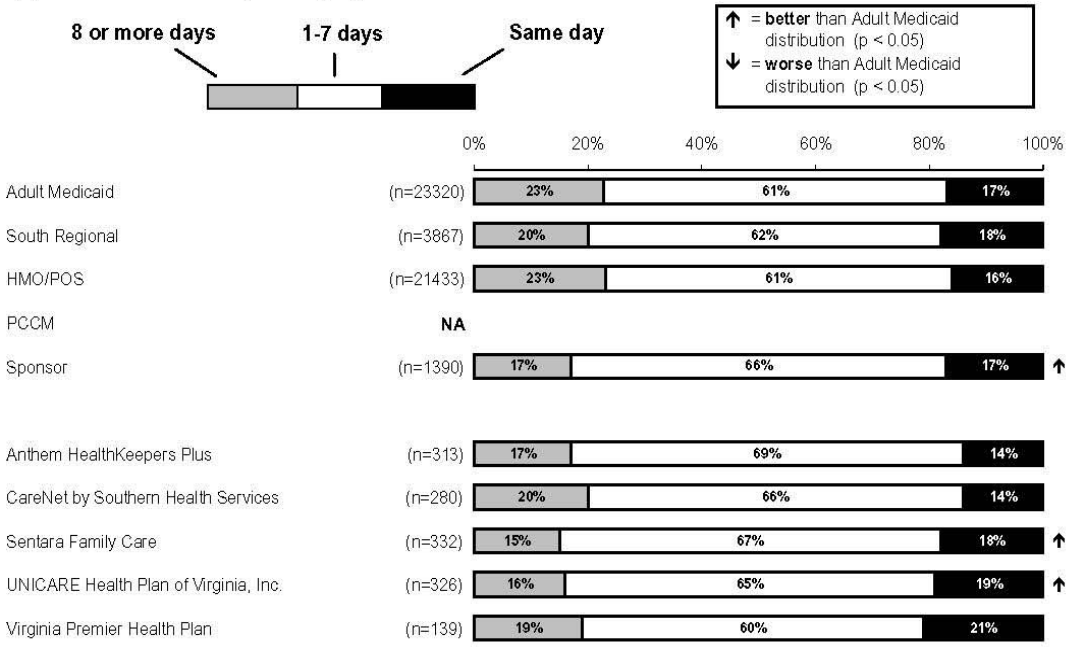
NCBD 2003 Adult Medicaid Sponsor Report B-35

VA Dept. of Medical Assistance Services

HEDIS Survey Item

Q20. Of those respondents who made an appointment for care: "In the last 6 months, not counting the times you needed health care right away, how many days did you usually have to wait between making an appointment and actually seeing a provider?"



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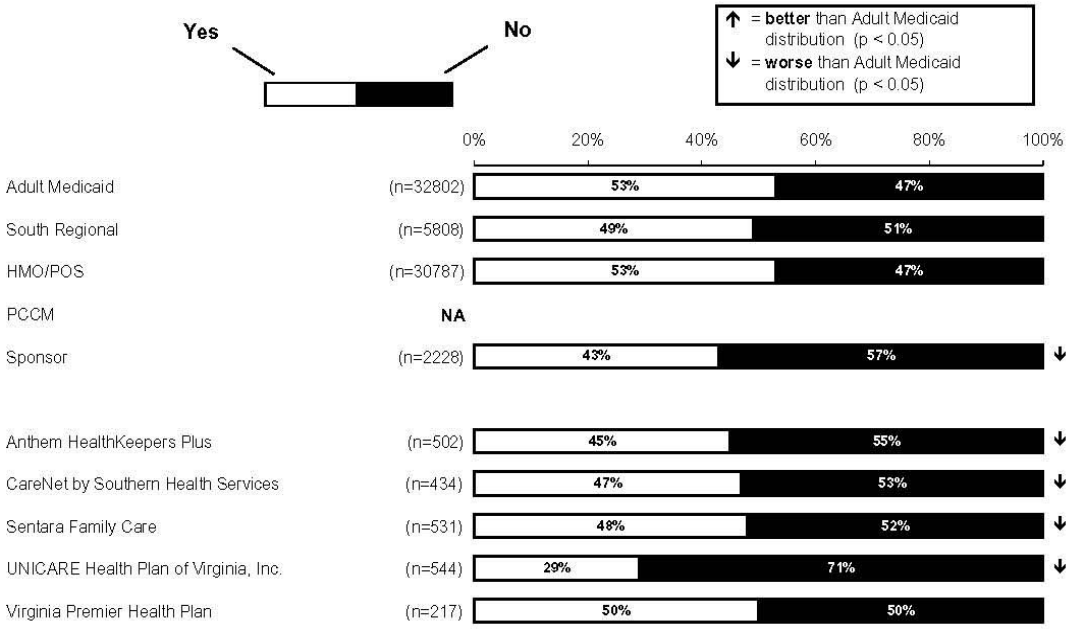
NCBD 2003 Adult Medicaid Sponsor Report B-36

VA Dept. of Medical Assistance Services

HEDIS Survey Item

Q54. Have you ever smoked at least 100 cigarettes in your entire life?



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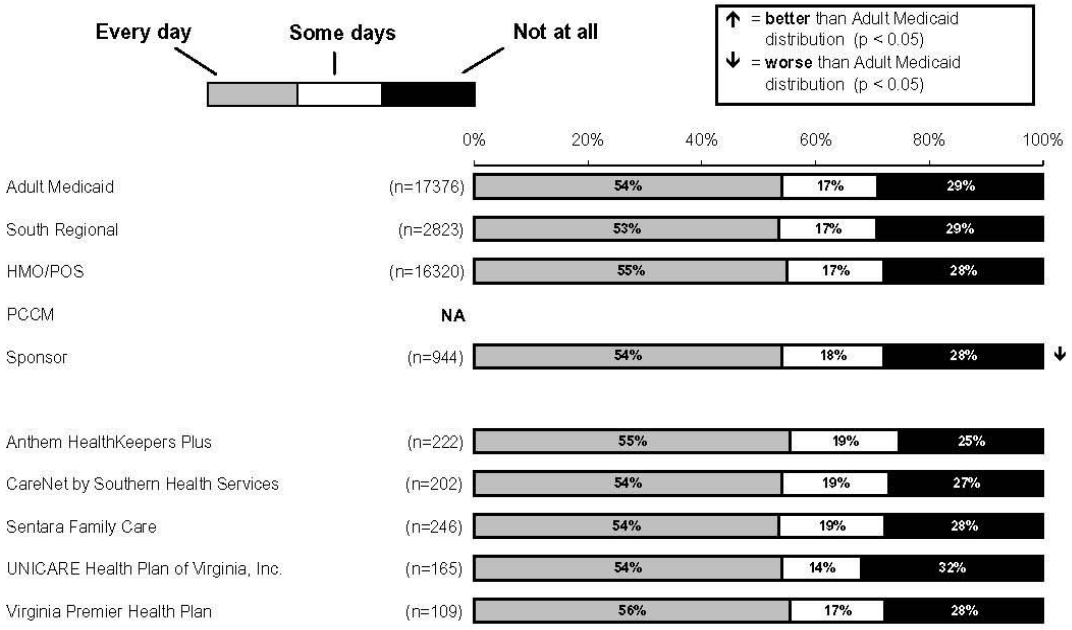
NCBD 2003 Adult Medicaid Sponsor Report B-37

VA Dept. of Medical Assistance Services

HEDIS Survey Item

Q55. Of those respondents who have smoked at least 100 cigarettes: "Do you now smoke every day, some days, or not at all?"



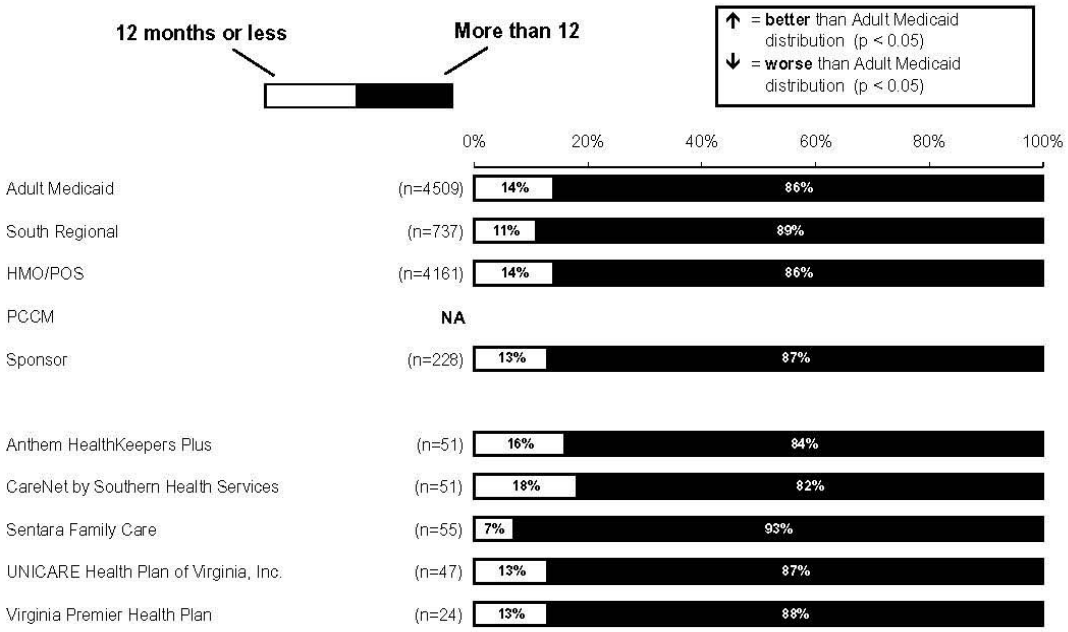
NOTE: The results shown above are case mix adjusted. Small percentage differences may represent measurement (sampling) error rather than actual differences in health plan performance. Response distributions may not sum to 100 percent due to rounding. See the methodology section for more information about the scoring and case-mix methodology.

NCBD 2003 Adult Medicaid Sponsor Report B-38

VA Dept. of Medical Assistance Services

HEDIS Survey Item

Q56. Of those respondents who have smoked at least 100 cigarettes and no longer smoke: "How long has it been since you quit smoking cigarettes?"



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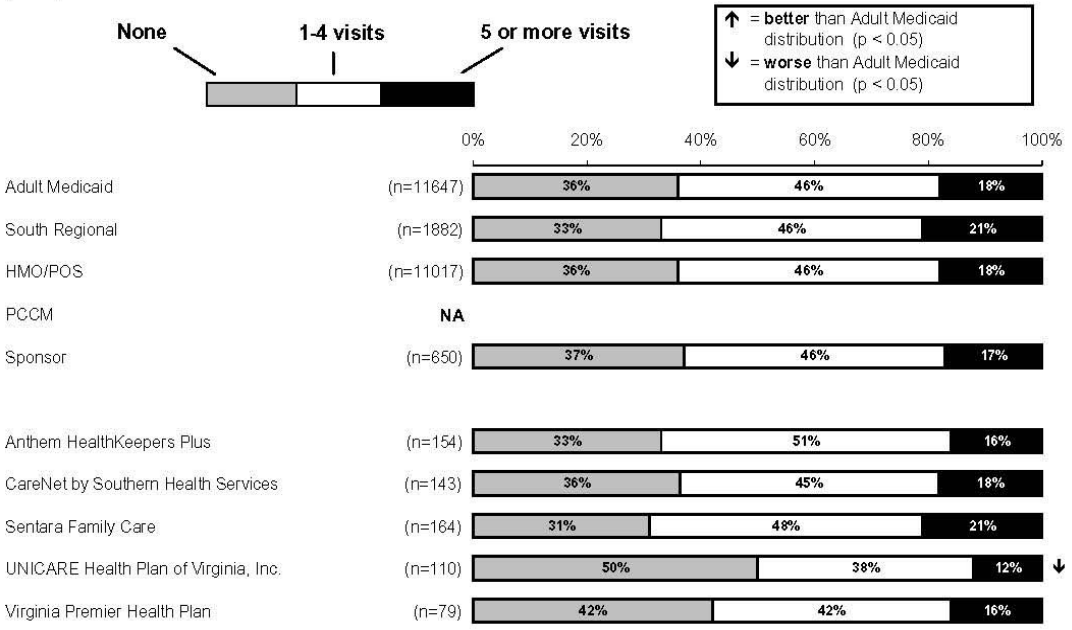
NCBD 2003 Adult Medicaid Sponsor Report B-39

VA Dept. of Medical Assistance Services

HEDIS Survey Item

Q57. Of those respondents who have smoked at least 100 cigarettes and have not quit smoking: "In the last 6 months, on how many visits were you advised to quit smoking by a doctor or other health provider in your plan?"



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NCBD 2003 Adult Medicaid Sponsor Report B-40

Appendix E – 2002 Immunization Study

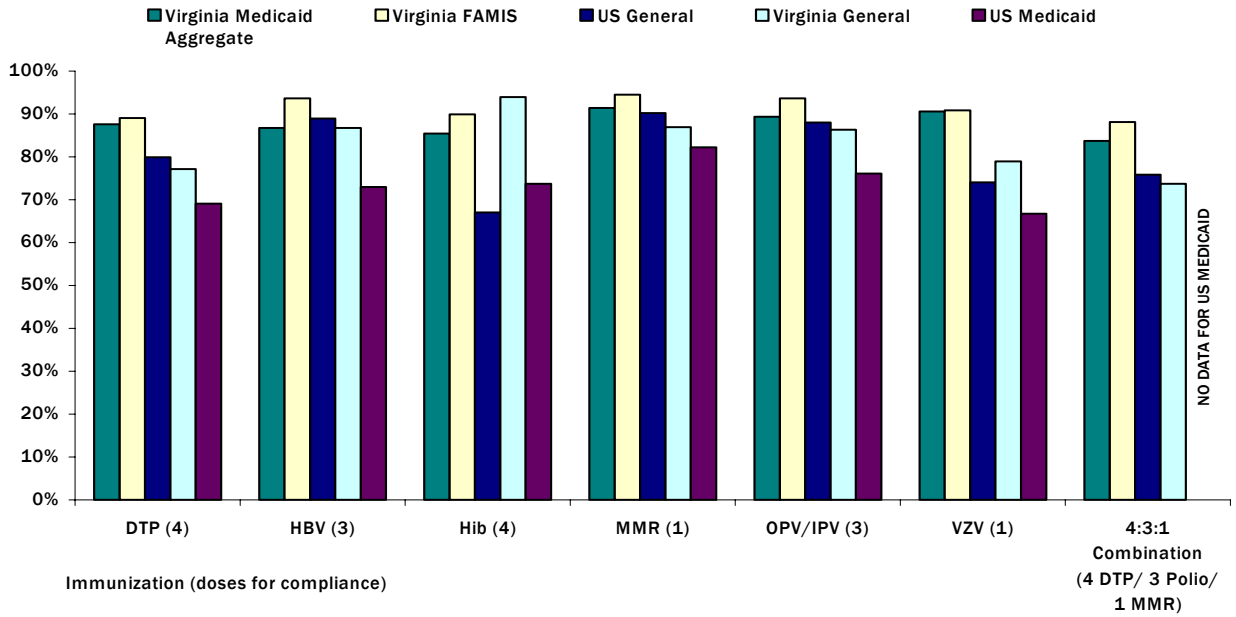
At-A-Glance: Study Overview

Immunization completion rates are a standard quality of care measure emphasized in both national and state Healthy People 2010 programs and the national Government Performance and Results Act (GPRA) initiative to increase the percentage of 2-year-old children who are fully immunized. Appropriate immunization completion is strongly associated with a reduction in preventable disease rates, and routine immunization has been described as a cost-effective and highly beneficial component of appropriate childhood medical care.

As part of its Quality Assessment and Improvement Program, the Virginia Department of Medical Assistance Services (DMAS) encourages the Medallion II Managed Care Organizations (MCOs) and Family Access to Medical Insurance Security (FAMIS) Managed Care Entities (MCEs) to implement projects aimed at increasing the number of 2-year-old children who are fully immunized. In addition, DMAS participates in the GPRA project aimed at increasing the immunization rates of all children in Medicaid and FAMIS. Virginia has set an ambitious immunization compliance target of 85%.

A review of medical records was conducted for a randomly selected sample of children in each of the Medicaid care delivery systems (MEDALLION, Medallion II, and fee-for-service) and for the FAMIS program. Detailed results for each care delivery system and program as well as trends and comparisons with state and national averages are available within this report. Statewide results are indicated in the following graph.

Figure E1. Virginia Medicaid Aggregate Immunization Status at 24 Months - SFY 2002



At-A-Glance: Conclusions

- In general, children served by Virginia Medicaid programs are at or above the immunization levels of the U.S. and Virginia general populations.
- Children served under the FAMIS program are at or above the Medicaid immunization levels.
- Compliance rates from SFY 1998 through SFY 2002 appear to be increasing moderately, with all of the immunization indicators (except the 4:3:1 combined series) at or above 85%.

Conclusions and Recommendations

The results demonstrate that Medicaid and FAMIS service providers have maintained an acceptable quality level in the area of childhood immunizations. Rates of compliance for specific antigens and a key series of immunizations (4:3:1) meet or exceed standards reported by Medicaid managed care programs through HEDIS®. A steady increase in the rate of VZV between 1998 and 2002 suggests that Virginia Medicaid and FAMIS providers have taken a proactive approach to increasing the rates of VZV immunization.

Continued efforts within a continuous quality improvement framework are needed to meet the growing demands placed on providers with respect to early childhood immunization. The growing numbers of vaccines and the complexity of vaccination schedules will make delivery of appropriate vaccinations in a timely manner increasingly more difficult. Educational efforts for both providers and parents of vulnerable children will be required to meet this challenge (see, e.g., Fitzgerald, 2000).

Immunization completion rates from 2000 to 2002 may have been negatively affected by vaccine shortages. Shortages in the supply of needed vaccines have been evident over the past 2 years. Shortages are a result of several factors. First, one of the two manufacturers of tetanus/diphtheria vaccine (DTP) exited the market in December 2000. In addition, the remaining manufacturer experienced an interruption in production, due to quality control issues, and existing stock was prioritized to hospitals, emergency rooms, and public clinics that treat acute wounds. According to a spokesperson at the Centers for Disease Control Vaccines for Children Program, in January 2002, 6 of the 51 regional Vaccines for Children depots had no DTP inventory, 27 had less than a 15-day supply, and 13 had a 16- to 30-day supply on hand.[1] Similar shortages are being experienced for the VZV and MMR vaccines. Disproportionate shortages have been experienced by public sector and private providers that depend on publicly purchased vaccines; Medicaid providers are required to use vaccines publicly purchased through the Vaccines for Children Program. This situation further reinforces the need for the formation of strategic alliances among health care providers and parents to provide the needed educational and outreach initiatives to ensure that enrollees continue to receive vaccinations.

The Government Performance and Results Act (GPRA) project has focused attention on state efforts to improve immunization compliance. Virginia has set an ambitious immunization compliance target of 85%. Other states have set targets that range from 60% to 90% with baseline measures of 19% to 82%.[2] Virginia has met its compliance target for all of the single customary immunizations. The combined series (4:3:1) is well within reach of this target at 84%.

Though immunization targets have been met, strategies for further improvement should be considered. As Medicaid and FAMIS programs work to improve the rates of early childhood immunization, the following issues need to be considered to optimize these efforts:

- Establishment of immunization registries and coordination of the delivery of needed immunization information to providers at the point of service are ways to provide feedback to providers regarding the immunization status of their patients (e.g., Miller et al., 1997; Wood et al., 1999).

[1]Mason, D. (Centers for Disease Control and Prevention). (2002, March). Presentation given at the Government Performance and Results Act Immunization Conference, Albuquerque, NM.
[2]Murphy, L. (Centers for Medicare and Medicaid Services). (2002, March). Presentation given at the Government Performance and Results Act Immunization Conference, Albuquerque, NM.

- Procedures to translate improvements in data to improvements in care should be implemented. For example, more accurate tracking of immunizations could permit targeted outreach efforts. Use of patient immunization tracking software may enable provider offices to further increase the rate of complete immunizations. Parents could be taught to access systems that could provide feedback regarding the immunization status of their children (e.g., Adams et al., 2000; Fitzgerald et al., 1998).
- Initiation of parental educational efforts, during the prenatal period, regarding the importance of childhood immunizations will provide early reinforcement of the need for childhood immunizations.
- Evaluation of the cost-effectiveness of changing primary care provider or clinic hours to enhance access to care may enhance parental compliance in obtaining the necessary immunizations.
- Development of outcome measures that capture the realized opportunity for immunizations at each visit may provide a more sensitive measure for assessing quality improvement efforts.

In conclusion, the Virginia DMAS care delivery systems and aid programs are performing better than the national rates for Medicaid and FAMIS programs in all vaccines. Upward trending in vaccination rates over the last 5 years indicates improving and stabilizing vaccination rates, with a slight decline in rates of Hib vaccination. However, the criterion for complete vaccination for the Hib series was increased from three to four vaccinations during the 2000 and 2002 study period, which may explain the decreased rate. Lastly, there was a dramatic increase in the rate of VZV vaccination from 1998 to 2002.

From a programmatic perspective, it is clear that the children served by the FFS system have marginally lower levels of vaccination across all vaccination types. The other programmatic assessments were not notably different. The FFS population appears to be an underserved population relative to the larger population of children served. This represents an opportunity for clinical quality improvement.

The high rates of immunization achieved by DMAS and its partners are commendable. Continued efforts by DMAS with the support if its partners and the Commonwealth of Virginia will most certainly ensure that high-quality preventive care is provided to Virginia's most vulnerable population.